COVID-19 EMERGENCY POWERS:

THE NEW ZEALAND STATE,
MEDICAL CAPTURE
&
THE ROLE OF STRATEGIC IGNORANCE
(2019-2022)

J.R. BRUNING APRIL 5, 2022.

COVID-19 Emergency Powers: The New Zealand State, Medical Capture & the Role of Strategic Ignorance.

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J.R. BRUNING MA SOCIOL (RES)

This critical essay is intended to spur robust and healthy public interest debate. The author aims to draw attention to the difficult work that is required to make a safe space for the production of the often uncomfortable, independent information that can draw attention to harms from new technologies.

Independently funded research and science is essential for the functioning of a robust, safe and healthy democratic society, and to assist civil societies to navigate risk situations which are often complex, uncertain and ambiguous. Such work is required as a necessary countermeasure to the assertions of institutional interests that produce and release novel technologies. The power of supranational institutions often exceeds that of nation states. There is unprecedented opportunity for human and environmental harm from these technologies; but also potential for financial and political abuse, to the detriment of human rights, human agency and human autonomy.

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SUMMARY

New Zealand's Unite Against COVID-19 'stamp it out', or 'elimination' strategy is revealing it's democratic and political deficit. The strategy relied on the deployment of policy, legislation and simple slogans focusing on case rates, vaccination, masking and mandates. Early 'elimination' based policies disregarded basic principles of public health, and effectively locked-in policy that conveyed that every 'case' was bad for New Zealand. This created the political conditions for acceptance of a novel and largely untested technology and the rapid production of democratically questionable legislation to legally enforce acceptance of the technology. At the same time, important public conversations regarding hospitalisation and death rates and age stratified risk, were not undertaken.

This paper applies a sociological approach to explore the methods used by New Zealand institutions to exclude inconvenient knowledge that might have compromised the Unite Against COVID-19 strategy. This paper recognises the basic truism, that all human institutions can be 'gamed' or manipulated in the interests of those with greatest access to the machinery of those institutions. From 2020-2022 it has been much easier to prescribe a medicine for all, than to respond individually (with proportionality) to improve and protect health.

As the pandemic progressed, waves of law-making were not accompanied by policy that reviewed the peer-reviewed literature to evaluate risk based on principles of *public health.* Literature reviews, as intelligence, could have reassessed – and communicated - the changing data on hospitalisation and death by age; and on the safety and efficacy of medical treatments *selected* by the state and *rejected* by the state. Lacking this basic intelligence, policy supporting law-making contained persistent errors of judgement. It could not be accurate, trustworthy and timely if known risks remained outside the policy literature. The Ardern Government prioritised modelling from a directly contracted institution for its 'evidence base'. Ethically relevant issues were ignored. For example, modelling excluded important considerations such as age-stratified risk and the role of natural immunity, as respiratory viruses become endemic across a population. Modelling ignored the fact that endpoints in the clinical trials did not require that the vaccine prevented transmission of infection.

Ignorance relating to relative risk produced a knowledge vacuum from 2020 to March 2022. Ethically and legally questionable mandates were constructed, which limited access to employment, state utilities and community engagement, unless the Comirnaty genetic vaccine was accepted. As if anticipating kickback, Te Pūnaha Matatini was contracted to research misinformation, disinformation and 'anti-vax' tactics.

The activities of the state reflect as much a medicalised culture as any nefarious, or conspiracy agenda. Before the mandates, the scientific literature signalled that: (a) the genetic vaccine was harmful; (b) that most of the population was not at risk from COVID-19; (c) that natural immunity was robust and long-lived; (d) that there were safe and inexpensive early treatments that could be used in place of a novel technology; and that (e) healthy groups were likely to be more at risk of harm from the genetic vaccine. However, there was little opportunity to debate this, as this information was outside both the scope of discussion promoted by the Unite campaign and the New Zealand media. In the process, the principle of informed consent was jettisoned.

COVID-19 rules have been demonstrably socially, economically and physically harmful. By mid-2021 the genetic vaccine was demonstrated to be more harmful than COVID-19 to many groups, including healthy pregnant women, children and young people. Yet data which inferred caution and hesitancy was excluded from policy. Long-established principles of infectious disease, which required that actions are proportionate to individual risks, have been overlooked.

This paper proposes that the combination of rapid output of legislation and flawed policy processes have produced deficient COVID-19 legislation, that was never scientifically nor democratically accountable. The use of narrowly formed modelling to justify strategies, were never balanced by scrutiny of the peer reviewed scientific literature. Laws that required that the public accepted a medical treatment in order to participate in economic life, continue to present grave ethical, legal and moral implications for human rights, and the resilience of democracies in times of crisis, in the years ahead.

1: SCIENCE AND DEMOCRACY

A healthy democracy must serve the common good, and decision-making must be accountable and transparent in order for it to be trustworthy. Science in the service of the public good must also conform to democratic norms of accountability and transparency. Yet data production and scientific knowledge are all too often, the product of political decision-making because science is expensive to produce. The decisions of our institutions shape the scope of data and information that is produced. For this is an expensive process, and not open to all.

Since time immemorial, the ancient Greeks, the time of Sun Tzu, (and before) political and economic cultures have directed resources to what Latour has described as 'centers of calculation'. Science is a resource, and the production of particular forms of science has long been recognised as tactically and politically useful in times of controversy. Also important, is science (or data) that is *not* produced. This is called *undone* science.[1] Because of the cost of data and science production, the dynamics of science and power are extraordinarily difficult to tease apart, and 'science and technology operate, in short, as political agents.'[2]

Objectivity, reliability and expertise in science, are directly related to who funds the science; how the scope of the research, science or innovation is crafted; and how expertise is recognised. Research and science are expensive to resource, and funding must be secured, for research and science to be undertaken. Proposals must therefore fit what is recognised as both legitimate and worthy, and policy and funding cultures inform how we approach technical and scientific problems, and deal with them. So while the production of data and scientific knowledge, is championed as 'apolitical', our overarching political, economic and social cultures shape the scope of what forms of research and science will be funded. Inevitably, it is not only policy makers that drive this process, but the historic legacy of the research and scientific communities. Thomas Kuhn's discussion on the innate conservativism of science, and the hesitancy of scientific communities to embrace new ways of thinking, or new paradigms, revealed how established interests often worked to repress new findings.

What results after these decisions are made, priorities are identified, and scopes established and funding granted - is data and science. As Sir Peter Gluckman has explained 'Science is not a collection of facts; science is a collection of processes which are defined to eliminate bias to the extent they can.'[3]

This is the trick. For thirty years Aotearoa New Zealand's science culture has been decoupled from critical, research and science that can draw attention to *harm* from social, political and economic activities. Our funding policies have *not* provided a safe space for research and science which by definition is controversial, because it challenges the activities of powerful institutions. The work required to draw attention to these harms is long term and interdisciplinary, requiring long-term funding. Our hyper-competitive funding environments have not provided a safe space for knowledge that might challenge economic priorities. Bias towards business as usual, has been built into the system.

The research and science environment framing COVID-19 provides a case study of the absence of a safe space for research and science that can counter the claims of public and private institutional interests. The two years to 2022 have resulted in an unprecedented stifling of data and scientific knowledge relating to both the risk of Covid-19; the risk of the novel mRNA vaccines and the presence of medications that could be deployed as an alternative to the novel mRNA vaccines.

Neither the public interest, nor democracy can be protected when power only permits knowledge and research to move in one direction. When the U.S. Centre for Disease Control sought to prevent release of data relating to the Pfizer vaccine, an appeal to a U.S. district court resulted in the judge ordering the release of those

[1] Hess, D. (2015). Undone science and social movements. A review and typology. In M. Gross, & L. McGoey (Eds.), Routledge International Handbook of Ignorance Studies (pp. 141-154). Routledge.
[2] Jasanoff, S. 2004. Ordering knowledge, ordering society. In States of knowledge: The co-production of science and social order, ed. S. Jasanoff, 13–45. London: Routledge.
[3] Gluckman, P. (2018). The role of evidence and expertise in policy-making: the politics and practice of science advice. *Journal & Proceedings of the Royal Society of New South Wales*, 151,1, 91-101. ISSN 0035-9173/18/010091-11

documents. The judge emphasised the intimate relationship between access to information and effective democratic stewardship. The judges' comment is worth repeating:

> "Open government is fundamentally an American issue"—it is neither a Republican nor a Democrat issue. As James Madison wrote, "[a] popular Government, without popular information, or the means of acquiring it, is but a Prologue to a Farce or a Tragedy; or, perhaps, both. Knowledge will forever govern ignorance: And a people who mean to be their own Governors, must arm themselves with the power which knowledge gives." John F. Kennedy likewise recognized that "a nation that is afraid to let its people judge the truth and falsehood in an open market is a nation that is afraid of its people." And, particularly appropriate in this case, John McCain (correctly) noted that "[e]xcessive administrative secrecy . . . feeds conspiracy theories and reduces the public's confidence in the government."[4]

The release and production of controversial information can be stymied by powerful institutions. Bringing up such questions raises a lot of uncomfortable knowledge.[5] This knowledge is uncomfortable because firstly, it may undermine the principles of powerful institutions and secondly, once brought to the surface it can reflect badly on the values, assumptions and priorities of these same powerful institutions.

NOVEL ENTITIES & RISK

Aotearoa New Zealand is spectacularly bad at researching risk arising from man-made technologies, or novel entities. Novel entities, defined as 'new substances, new forms of existing substances and modified life forms, including 'chemicals and other new types of engineered materials or organisms not previously known to the Earth system as well as naturally occurring elements (for example, heavy metals) mobilized by anthropogenic activities.'[6] Novel entities can be persistent, bioaccumulative and toxic (PBT), harming at the level of a single human, or at the level of an ecosystem. PBT qualities, which are often not recognised or declared when the product is released, not only impair our capacity to protect and steward human and environmental health in the short term, but also to uphold or commitments to intergenerational justice.

Novel entities are embedded in economic life, and governments must balance the conflict of promoting business while regulating the adverse and off-target effects resulting from business activities. This has not been done very well, and the escalating risk from release of novel entities currently vastly exceeds (feeble) institutional efforts to regulate them.[7]

By not ensuring a safe space for uncomfortable science that can question the potential for novel entities to harm health, governments fail to uphold basic tenets of administrative and constitutional law. Research and science to regulate should have kept pace with the research and science to produce, but it never has done so. In such a world, it has been impossible to prioritise the public interest. Such work has an important place, as it provides information to both the public and policy-makers, so that they may deliberate from such a place that represents the public interest, and is not weighted to the interests of powerful institutions that may profit politically or financially. Yet this work has been defunded and undervalued, and the research and science

[4] United States District Court for the Northern District of Texas Fort Worth Division. Public Health and Medical Professionals for Transparency (Plaintiff) *v*. Food and Drug Administration. Case 4:21-cv-01058-P Document 35 Filed 01/06/22 https://www.sirillp.com/wp-content/uploads/2022/01/035-Order-ad449f90c822d03d87562aec5f68f6b9.pdf
[5] Rayner, S. (2012). Uncomfortable knowledge: the social construction of ignorance in science and environmental policy discourses. *Economy and Society*, 41(1), 107-125. https://doi.org/10.1080/03085147.2011.637335
[6] Persson, L., (2022) Outside the Safe Operating Space of the Planetary Boundary for Novel Entities. Env. Sci. Technol., https://doi.org/10.1021/acs.est.1c04158
[7] Persson, L., (2022) Outside the Safe Operating Space of the Planetary Boundary for Novel Entities. Env. Sci. Technol.,

dedicated to exploring risk is decades behind the development laboratories in commercial-in-focus institutions.

Yet, as Sir Peter has recognised, 'where science is of most use is actually where the science is most contested. Governments are usually making decisions in situations where the science is not complete; it can never be complete and it's often most contested. And we now face this challenge that the science of the most interest to governments is actually in areas which are most contested in terms of public values.'

Sir Peter has noted that science should not be a proxy for values debates. He recognises that complex and controversial decisions intersect with what he considers to be 'community values' but which might also be recognised as democratic norms. These values are, according to Sir Peter, are 'disputed'.

Disputes tend to concern the intersect of novel entities and biological risk, whether to humans or the environment (flora, fauna or ecosystems). Harm might arise from new commercial activities, claimed safety of a new technology, recognised pollutant emissions, or establishing risk over aggregating harm that might be arising from previously considered exposures to claimed benign technologies or polluting activities.

Of course, the point where a biological system *starts* to be harmed from a technology or polluting activity differs by maturity of that system, and historic and current stressors on that system. The potential for cascading, or ripple effects that create irreversible harm can shape how seriously we are likely to regulate a harm.[8] However, if the science remains undone around the extent of harm, and harm is unknown or under-appreciated it can be difficult to bring the issue into the public sphere. This is often the case for neurodevelopmental or endocrinological harm in early infancy and childhood. This makes it difficult to stop the harm in a timely manner.

Because of this complexity, there is no one form of science that is appropriate to demonstrate risk between a technology and a biological system. Risk is rarely linear, and harm often has a cascading and irreversible effect on biological systems. Risk is will therefore always be a judgement call, depending upon a broad range of expertises to make that judgement, in the public interest.

Data and science therefore have an important role in legitimating political controversies. Harms commonly concern commercial activities and the release of PBT novel entities (as pollution, as ultraprocessed food, as pharmaceuticals, as pesticides) which aggregate inside biological systems.

In this context science is powerful, with power: 'the ability to influence others directly or indirectly, subtly or overtly, legitimately or illegitimately'.[9]

Today, no publicly paid researcher would want to be seen persistently criticising commercial activities, it would be tantamount to career suicide and would impair the chance for future research funding.

INFANTS, CHILDREN & YOUNG PEOPLE

The disputed *values* concern what and how we value an entity. The protection of the health of children and young people is a 'value' that officials and risk analysts find very hard to prioritise. Therefore authoritative, scientific knowledge considering risk from manmade technologies to pregnant women, children and young people, in New Zealand is precarious and often non-existent. It's well established that environmental factors predominantly shape our risk for disease in adulthood, and that these are frequently set in place in the early years.[10] It's clear that novel entities contribute to our human 'exposome' - the range of exposures to synthetic

[8] Scott D. Application of the Precautionary Principle During Consenting Processes in New Zealand: Addressing Past Errors, Obtaining a Normative Fix and Developing a Structured and Operationalised Approach (LLM Thesis, Victoria University of Wellington, 2016)
[9] Frickel, S., & Moore, K. (Eds.). (2006). The New Political Sociology of Science. The University of Wisconsin Press. p.8
[10] Barouki, R. et al. (2012). Developmental origins of non-communicable disease: Implications for research and public health. *Environmental Health,* 11, 42. https://doi.org/10.1186/1476-069X-11-42

chemicals, pharmaceuticals, dietary constituents, psychosocial stressors, and physical factors, as well as their corresponding biological responses.[11] [12]

Yet in Aotearoa New Zealand, there is no place for the research risk in this arena. The state does not direct funding to understand risk to the developing infant and child from novel entities. The Crown Research Institute that was likely to do this work, Gravida, faded away. Our brain institutes don't seem to explore environmental chemicals and neurodevelopmental toxicity. Pregnant women, babies, children and young people require particularly precautionary and values-based policy development, because vulnerability to an exposure is almost impossible to estimate. If harm occurs, it can produce much greater lifetime costs, than if similar harm were to occur in a mature adult.

How we value is a function of what we know. If the data and science is not produced to understand harm, there results in a knowledge chasm around how that risk might manifest. In times of contestation, the evidence that is produced and seen as legitimate, is just as important. Our society can claim we value pregnant women, infants and children. However, if our research and science is resourced to prioritise economic activity, rather than stewardship (and the uncomfortable knowledge that surfaces with evidence), our society can never claim that pregnant women, infants and children are valued.

Interaction of technology and human biology will never produce a consistent result. It will be forever uncertain. The recommendation that not at-risk children are vaccinated, in order to protect families demonstrates just how far medicalisation pervades contemporary New Zealand culture. Traditionally the protection of pregnant women, infants and children – *as well as* the elderly and disabled - has been the raison d'être of community life. Harm in infancy and childhood produces profound economic costs across the life course. However, healthy children and pregnant women were asked to accept a novel genetic vaccine[13] that has a paucity of supporting data, so that they might protect much older people towards the end of their life. There are other ways policy measures can increase safety for everyone. [14] As every toxicologist and doctor recognises, there is always a risk from medication, and vaccines are particularly precarious, which is why vaccine producers secure indemnity from risk. The government did not make a safe place to establish appropriately informed policy, and instead produced campaign messaging and social and economic pressure that undoubtedly placed the majority of pregnant women, children and young people at risk.

INFORMED POLICY & INTERDISCIPLINARY COLLABORATION

The case focus which has driven the regulations and the traffic light system and the case-focussed modelling, is an example of New Zealand's historically blinkered and narrow approach to public interest risk governance and human and environmental health. Risk governance concerns how societies navigate complexity, scientific uncertainty, socio-political ambiguity and prevent the potential for unanticipated, off target, or cascading effects that are irreversible.[15]

It's often political. In New Zealand, very little funding has been directed to the production of scientific knowledge which might clarify contested technologies that have potential to risk or set in place human and environmental health harms. This includes medical technologies.

Yet when decision-makers focus on a specific metric and clarify a *boundary*, they set a value *judgement*.

Deliberation means that we consider the broadest possible group of alternatives, in order to produce a judgement that is most reflective across society. The only way to move forward to ensure accountability and

[11] Vermeulen, R. et al (2020). The exposome and health: Where chemistry meets biology. *Science,* 367, 392-396,
[12] González-Domínguez, R. et al (2020). Characterization of the Human Exposome by a Comprehensive and Quantitative Large-Scale Multianalyte Metabolomics Platform. *Analytical Chemistry,* 92,13767-13775. https://dx.doi.org/10.1021/acs.analchem.0c02008
[13] Nakagami, H. (2021). Development of COVID-19 vaccines utilizing gene therapy technology. International Immunology, 33:10;521-527. https://doi.org/10.1093/intimm/dxab013
[14] Halperin et al 2021. Revisiting COVID-19 policies: 10 evidence-based recommendations for where to go from here.
[15] Renn, O. (2021). New challenges for risk analysis: systemic risks. New challenges for risk analysis: systemic risks, *Journal of Risk Research,* 24, 1, 127-133. https://doi.org/10.1080/13669877.2020.1779787

transparency at arm's length of the institutions with the vested (political and financial) interest. To remove conflicts of interest and draw attention to bias. This should ensure a safe space for contestation and deliberation and to make sure the fora is interdisciplinary so that judgements reflect complex scientific, ethical, legal and social issues around risk. This will never be apolitical – it will always be messy and political. Such work requires long term block funding.

2: UNCOMFORTABLE KNOWLEDGE, ESSENTIAL FOR ROBUST DEMOCRACY

This conversation is distinctly uneasy, but it is *of the essence* that democratic societies support and encourage citizens, experts and public servants to raise politically, culturally and socially controversial and contradictory questions. It was the Roman historian Tacitus (55-120 AD) who stated, 'If you would know who controls you, see who you may not criticise.' For comment, critique and consensus must not be the exclusive bastion of the same government institutions who develop the laws, rules and regulations. For that is tyranny.

Drawing attention to the larger landscape of risk from manmade technologies, or novel entities, the production of science and the veracity of democracy is important because the COVID-19 mRNA vaccines are but one subset of a technology landscape that is expanding at an increasing rate.

Technologies in the twenty-first century and applied by big data, big pharma, big media, big biotech and big food, aggregate as power across large transnational institutions, and they develop and resource institutions, that, lacking civic and democratic transparency and accountability, serve the interests of those institutions. These institutions have much greater access to the machinery of government than most civic groups.[16] We see institutional power acting to concretely influence representative democracy in the twenty-first century, in the form of Brexit[17] [18] and in the actions of the World Economic Forum.[19] In such environments, where the networked landscape between government and business is deeply integrated, and where large platforms are funded to develop glamourous conference opportunities; rather than promoting dialogue that can strengthen democracy, the ties, the commercial in confidence agreements and business deals, are more inclined to block it.[20] These democratic dilemmas are well established in the scientific literature and not the stuff of conspiracy theory. [21] [22]

It is therefore particularly essential that in times of controversy that the state engages with the public and with dissenting experts. Where there is absence of social movements to counteract industry-regulator relationships, regulatory policy tends to follow in the direction established by industry. Commercial industries dedicate resources to the production of science that is designed to ensure that products are not regulated or under-regulated. and therefore, kept on the market. Public contestation, and publicly resourced science is the antidote to that power. As Professor David Michaels has noted, 'law and regulation are the underpinnings of the free market system (…) the state fosters a safe space for market growth.'[23] Yet if there is no evidence, of harm, regulation will lag.

Because business, is business. Powerful institutions have the capacity to tactically and covertly evade norms of accountability and transparency, particularly through opaque secrecy provisions, and engage in co-governance activities which erode human rights and human health. In 2021, consultation commenced on the Digital Identity Services Trust Framework Bill. The enfolding of private data into singular identity systems,

[16] Bimber, B. (2003). Information and American Democracy: Technology in the Evolution of Political Power. Cambridge University Press.
[17] Entman, R.M. (2018). Framing in a Fractured Democracy: Impacts of Digital Technology on Ideology, Power and Cascading Network Activation. *Journal of Communication*, 68, 2, 298–308. https://doi.org/10.1093/joc/jqx019
[18] Grayling, A.C. (2017). *Democracy and its Crisis.* Oneworld Publications. P.203
[19] World Economic Forum 2019. A Platform for Impact. https://www3.weforum.org/docs/WEF_Institutional_Brochure_2019.pdf
[20] Feenberg, A. (1992). Subversive Rationalization: Technology, Power, and Democracy. *Inquiry*, 35,301-322. Subversive Rationalization: Technology, Power, and Democracy. Inquiry, 35,301-322
[21] Macdonald, T. (2008). Global Stakeholder Democracy: Power and Representation Beyond Liberal States. Oxford University Press.
[22] Arlblaster, A. (2002). Democracy. Concepts in the Social Sciences, 3rd Ed. Open University Press.
[23] Michaels, D. (2020). The Triumph of Doubt. Dark Money and the Science of Deception. Oxford University Press.

carries with it significant human rights implications,[24] and the potential for political and financial misconduct are significant, as these technologies are opaque, and government contracts will likely be undisclosed to the public.[25] At the same time there is discussion of transition to complete digital currency platforms which would place tremendous political and reserve power with reserve banks and the state. Lacking rigorous democratic provisions, there is capacity for institutional abuse at scale.

The proposed Digital Identity bill did not grant regulatory teeth to the proposed governance entity, nor provide resourcing pathways and a mandate to proactively patrol the local and global digital environs to ensure that the governance board could anticipate and prevent abuse. Not providing regulators with the financial clout to actively monitor and chase down the regulated is the oldest trick in the book. In Digital Identity systems, some of the regulated will be the most powerful global institutions in the world and the digital world is dauntingly opaque and highly predatory. Without a legal obligation to act at multiple levels to ensure ongoing observation and reporting on the activities of the potentially contracted bodies, either globally or locally, public protection cannot be achieved. The policy that led to the drafting of the Bill was narrowly consulted upon, and the public were excluded. Some four thousand submissions indicated that a large sector were sceptical of the capacity of the legislation and potential governing institutions to protect the public interest.

This may help explain why the strategic and tactical actions of the Ardern government to achieve over 90% take-up for a novel and risky COVID-19 mRNA vaccine, is but a canary in a powerful, highly technological coalmine. The scientific literature did not support vaccine mandates. Historically, the mRNA technology would not have fitted the definition of a vaccine and that in normal circumstances, this technology would have undergone substantially more pre-market testing. [26] Vaccine mandates were contrary to historic principles of public health; ignored the important role of herd immunity, and the scientific recognition that coronaviruses mutate rapidly and would be expected to evade the mRNA vaccine in a relatively short time. But still the mandates were imposed and enforced, with the Director General of Health Ashley Bloomfield denying nearly all requests for exemptions to the mandates, including in people who had previous adverse reactions.

The Ardern governments' deliberate action to manufacture consent within the population to accept extra-ordinary rights-limiting regulatory and enforcement mechanisms based on a technology with very short-term safety data, sets an extraordinary precedent for future pandemics. Solutions which depend on claims arising from the pharmaceutical and other industries with direct finanical interest in outcomes, create an environment with remarkable potential for abuse. The BNT162b2 or Comirnaty genetic vaccine accounted for 45% of Pfizers revenue in 2021, the 3 billion doses producing an income of USD36.8 billion, In 2022 the revenue was expected to be $32 billion from the genetic vaccine and $22 billion from the antiviral drug Paxlovid.[27]

Contestation, debate and protection of the public interest are *essential themes* coursing through democratic nations. An effective democracy *is* always uncomfortable. The protection of human and environmental health inevitably involves a clash with economic interests.

Such uncomfortable discussions will continue long into the future, as Toby Ord has discussed at length. Humanity's existential threats will predominantly revolve around the stewardship of technologies in the public interest, and the restriction and regulation of technologies that harm and/or that lead to excesses of power.[28]

New Zealand may be moving away from democracy more swiftly than publicly recognised, as, ironically, technologies have accelerated extensive webs of communications between nation-states and powerful institutions. These webs extend far beyond the reach of the general public, they are entrenched and highly resourced. As the technologies, mechanisms and public-private institutional relationships continue to be

[24] Renieris E.M. (2021). *Human Rights & the Pandemic: The Other Half of the Story.* Carr Center Discussion Paper Series. Fall 2021. https://carrcenter.hks.harvard.edu/files/cchr/files/renieris_human_rights_and_the_pandemic.pdf
[25] PSGR 2021. Digital Identity Bill Submission. Physicians and Scientists for Global Responsibility New Zealand.
[26] Kostoff et al. (2021) Why are we vaccinating children against COVID-19? Toxicology Reports 8:1665–1684
[27] Richterm F. (2022, Feb 9). Pfizer Revenue Boosted by Covid-19 Drugs https://www.statista.com/chart/25434/pfizer-annual-revenue/
[28] Ord T. *The Precipice.* Bloomsbury Publishing. 2020.

financed, similar resourcing to promote technologies and mechanisms to buttress democracy and support civic responsibility has not been provided.

Instead, as Sir Geoffrey Palmer and Andrew Butler have noted 'the New Zealand style of government is already authoritarian'.[29] Without instituting, updating and safeguarding our democratic institutions,[30] [31] New Zealand culture ultimately pivots to genuflect to special, and often economic interests – much of which lie offshore and are spectacularly unaccountable.

3: COVID-19 & THE DEMOCRACY DEFICIT

Aotearoa New Zealand's legacy failure to provide a safe place for critical research and public debate was demonstrably brought to life in the Covid-19 pandemic. From the earliest, most pregnant women, children and young people were not at risk.[32] [33] [34] Yet there were systemic barriers to groups who sought to express any doubt relating to the safety and efficacy of this novel entity – the novel mRNA vaccine. There was no safe space to articulate the differential risk to children and young people from exposure to a technology in New Zealand media.

Modelling and communications avoided important research concerning vaccine efficacy and safety and the differential and very personal risk for those struggling with immunosuppression and persistent inflammation. After age and infirmity, profound multimorbidity – presence of multiple health conditions and associated polypharmacy - is the biggest risk factor for hospitalisation and death and this was known in 2020.[35] [36] [37] [38] [39] [40] [41] [42] [43] [44] as well as immunosuppression and vaccine failure.[45] From 2020, scientists recognised that morbidity status of individuals with COVID-19 was an important factor when defining patient triage for hospitalization.[46]

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[29] Palmer G. & Butler A. 2018. *Towards Democratic Renewal.* Victoria University Press.
[30] Grayling, A.C. 2017. *Democracy and its Crisis.* Oneworld Publications.
[31] 7 Boston et al. (2019) Foresight, insight and oversight: Enhancing long-term governance through better parliamentary scrutiny. Institute for Governance and Policy Studies, Victoria University of Wellington. ISBN 978-0-473-48292-3
[32] COVID-19 in children (2020, May 2). Covid-19 in Children. https://www.health.govt.nz/system/files/documents/publications/covid-19-in-children-2may2020-v2.pdf
[33] Kostoff et al. (2021) Why are we vaccinating children against COVID-19? *Toxicology Reports* 8:1665–1684
[34] Ibrahim et al. The characteristics of SARS-CoV-2-positive children who presented to Australian hospitals during 2020: a PREDICT network study. MJA 215:5 6 September (2021)
[35] Al Heialy S., et al (2021). Combination of obesity and co-morbidities leads to unfavorable outcomes in COVID-19 patients. *Saudi J. Biol. Sci.* 28, 1445-1450. https://doi.org/10.1016/j.sjbs.2020.11.081
[36] Steyn et al. (2020). Estimated inequities in COVID-19 infection fatality rates by ethnicity for Aotearoa New Zealand. Te Pūnaha Matatini. April 14, 2020. Unpublished report https://cpb-ap-se2.wpmucdn.com/blogs.auckland.ac.nz/dist/d/75/files/2020/04/Estimated-ifrs_draft12.ACTUALFINAL.pdf
[37] Fernández-Niño JA. et al. (2020) Multimorbidity patterns among COVID-19 deaths: proposal for the construction of etiological models. *Rev Panam Salud Publica*, 44 https://doi.org/10.26633/RPSP.2020.166
[38] McQueenie, R. (2020). Multimorbidity, polypharmacy, and COVID-19 infection within the UK Biobank cohort.*PLOS ONE*, 15, 8, e0238091. https://doi.org/10.1371/journal.pone.0238091
[39] Ecks, S. Multimorbidity, Polyiatrogenesis, and COVID-19. *Medical Anthropology Quarterly*, https://doi.org/0.1111/maq.12626
[40] Patel et al 2020. Poverty, inequality and COVID-19: the forgotten vulnerable. Public Health.183: 110–111.
[41] Michalakis & Ilias 2020. SARS-CoV-2 infection and obesity: Common inflammatory and metabolic aspects. *Diabetes & Metabolic Syndrome: Clinical Research & Reviews.* 14:469-471
[42] Malas 2020 Thromboembolism risk of COVID-19 is high and associated with a higher risk of mortality: A systematic review and meta-analysis. *Arthritis & Rheumatology*. Doi 10.1002/art.41285
[43] Moore et al 2021 Modelling optimal vaccination strategy for SARS-CoV-2 in the UK. PLOS *Computational Biology.* 17, 5, 1008849https://doi.org/10.1371/journal.pcbi.1008849
[44] Ruocco et al.(2020) Mortality Risk Assessment Using CHA(2)DS(2)-VASc Scores in Patients Hospitalized With Coronavirus Disease 2019 Infection. *The American Journal of Cardiology.* https://doi.org/10.1016/j.amjcard.2020.09.029
[45] Wang et al, 2021. A potential association between immunosenescence and high COVID-19 related mortality among elderly patients with cardiovascular diseases. *Immunity & Ageing* 18:25
[46] Fernández-Niño, J.A. et al. (2020) Multimorbidity patterns among COVID-19 deaths: proposal for the construction of etiological models. *Rev Panam Salud Publica*, 44, https://doi.org/10.26633/RPSP.2020.166

The Pfizer clinical trial reports had also acknowledged that multimorbid and immunosuppressed groups were not accurately reflected in trial participants, and therefore the response to these groups from mRNA vaccination was less understood.[47]

No local research or analysis was undertaken to assess the scientific literature pointing to the role of early, ambulatory multitarget treatment[48] in promoting autonomy and preventing hospitalisation and death. Early ambulatory multitarget treatment was identified as important for groups with less robust immune systems. It was identified as important in addressing the cascading effects, the cytokine storm that could be set off in vulnerable people.[49] Early treatments as a pathway for pregnant women, children and young people and for Māori and Pasifika were never publicly discussed. An important consideration was the potential for early treatment to have an effect as the vaccine waned or failed against newer variants. The vaccine was likely to have less effect as the coronavirus (naturally) evolved, as the variants mutated away from the genetic material in the increasingly out-of-date novel mRNA vaccine, and while the population formed immunity to circulating variants. This sort of data was never modelled, and science was never produced.

Somewhat startlingly, policies were never established to improve access to nutrition, nor confront the obesogenic environment low socio-economic groups are confronted with, despite diet being the major driver of multimorbidity. For a Wellbeing Labour government with a parliamentary majority, to not take action to reduce obesity – a risk for communicable and non-communicable disease, and a condition commonly burdened by multiple associated health conditions, - was a staggering moral failure. Exercise could also have a strong protective effect in preventing severe COVID-19 outcomes.[50] Anecdotal reports told of how immunovulnerable patients with health conditions were unable to access gyms or public swimming pools, because they did not have a vaccine pass.

In New Zealand medical equity, rather than health equity drives health policy, and the voice of nutrition is 'alarmingly quiet.'[51] In New Zealand, it is more common to have multiple conditions than a single condition.[52] Social factors, including inequality and racism drive multimorbidity risk.[53] [54] [55] [56] [57] [58] New Zealand's food environment is obesogenic.[59] New Zealand adults have the third highest rate of obesity and children the second highest prevalence of obesity within OECD and EU countries. For decades, governments have failed to address the drivers of non-communicable disease.[60] [61] Regulation of social, economic and structural drivers

[47] Pfizer and BioNTech (2020, Dec 10). Vaccines and Related Biological Products Advisory Committee Meeting.
[48] McCullough, P.A. et al. (2020). Multifaceted highly targeted sequential multidrug treatment of early ambulatory high-risk SARS-CoV-2 infection (COVID-19). Reviews in Cardiovascular Medicine, 21(4), 517-530. https://doi.org/10.31083/j.rcm.2020.04.264
[49] Marik, P.E. et al. (2021) A scoping review of the pathophysiology of COVID-19. International Journal of Immunopathology and Pharmacology, 35, 20587384211048026 https://doi.org/10.1177/20587384211048026
[50] Steenkamp, L. et al (2022). Small steps, strong shield: directly measured, moderate physical activity in 65 361 adults is associated with significant protective effects from severe COVID-19 outcomes. *British Journal of Sports Medicine*, https://doi.org/10.1136/bjsports-2021-105159
[51] Coad J. & Pedley K. (2020) Nutrition in New Zealand: Can the Past Offer Lessons for the Present and Guidance for the Future? *Nutrients* 2020, 12, 3433; doi:10.3390/nu12113433
[52] Millar, E., Dowell, A., Lawrenson, R., Mangin, D., & Sarfati, D. (2018). Clinical guidelines: what happens when people have multiple conditions. *NZMJ*, 73-81.
[53] Marmot, M. (2018). Medical Care, Social Determinants of Health, and Health Equity. *World Medical and Health Policy*, 195-197.
[54] Reynolds et al 2020. Food and vulnerability in Aotearoa/New Zealand: A review and theoretical reframing of food insecurity, income and neoliberalism. *New Zealand Sociology* 35:1;123-152
[55] Came et al 2019. Representations of Māori in colonial health policy in Aotearoa from 2006-2016: a barrier to the pursuit of health equity. *Critical Public Health.* doi 10.1080/09581596.2019.1686461
[56] Came, H. (2012). Institutional racism and the dynamics of privilege in public health. (Unpublished doctorate), Waikato University, Hamilton, New Zealand. http://researchcommons.waikato.ac.nz/handle/10289/6397
[57] Russell et al 2019. Multimorbidity in Early Childhood and Socioeconomic Disadvantage: Findings From a Large New Zealand Child Cohort. *Academic Pediatrics*, 20(7), P619-627.
[58] Beavis 2019. Exploration of Maori household experiences of food insecurity. *Nutrition & Diatetics* 76:344-352
[59] Wild et al. (2020) Challenges of making healthy lifestyle changes for families in Aotearoa/New Zealand. *Public Health Nutrition*, 24, 7, 1906–1915
[60] King, A. 2001. The New Zealand Health Strategy. Wellington: Ministry of Health
[61] Ajwani et al 2003. Decades of Disparity. Ethnic Mortality Trends in New Zealand 1980-1999. Wellington: Ministry of Health and University of Otago.

of disease have been kept outside government policy agendas for decades.[62] [63] [64] [65] Food banks have become busier, yet do not fill a nutrition gap, and people experiencing food insecurity and food banks experience even more deficient diets.[66] [67] [68] The presence of multiple health conditions escalate health care costs.[69]

While modelling recognised the risk to Māori and Pasifika was published[70] subsequent communications and paid advertising directed all people towards vaccination, continuing through February and March. Vaccinate all strategies ignored the potential for harm to those not at risk to Covid-19 and inferred that the booster would be protective against Omicron (though there was no transparency as to how long this protection would last). Even as benefits from boostering in Omicron grew increasingly doubtful, no information concerning optional early ambulatory treatment to protect individuals from hospitalisation and death were promoted or discussed by the Unite Against Covid Campaign.

[62] Baker et al. (2018). What Enables and Constrains the Inclusion of the Social Determinants of Health Inequities in Government Policy Agendas? A Narrative Review. *Int J Health Policy Manag*, 7(2), 101-111. https://doi.org/10.15171/IJHPM.2017.130
[63] Mackay, S., Gerritsen, S., Sing, F., Vandevijvere, S., Swinburn, B. (2022) Implementing healthy food environment policies in New Zealand; nine years of inaction. *Health Research Policy and Systems*, 20,8. Retrieved from: https://health-policy-systems.biomedcentral.com/articles/10.1186/s12961-021-00809-8
[64] Baum, F. (2019). Governing for Health: Advancing Health and Equity through Policy and Advocacy. *Oxford University Press.*
[65] Warhurst L. Jacinda Ardern 'rules out' introduction of sugar tax despite rising numbers of diabetes. Stuff October 9, 2019. https://www.newshub.co.nz/home/lifestyle/2019/10/jacinda-ardern-rules-out-introduction-of-sugar-tax-despite-rising-numbers-of-diabetes.html
[66] Neuwelt-Kearns et al 2021 The realities and aspirations of people experiencing food insecurity in Tāmaki Makaurau. *Kōtuitui: New Zealand Journal of Social Sciences Online*. DOI: 10.1080/1177083X.2021.1951779
[67] Dey 2014 Recounting food banking a paradox of counterproductive growth https://apo.org.au/node/52943
[68] Riches 2012. Thinking and acting outside the charitable food box: hunger and the right to food in rich societies. *Development in Practice* 21:4–5
[69] Blakely et al 2019. Health system costs for individual and comorbid noncommunicable diseases: An analysis of publicly funded health events from New Zealand. *PLOS Medicine*, e1002716.
[70] Steyn, N. et al. (2021). Māori and Pacific people in New Zealand have a higher risk of hospitalisation for COVID-19. NZMJ 134(1538), 38-43 P.38. https://assets-global.website-files.com/5e332a62c703f653182faf47/60e6167dc6a453d0e48e553c_5049%20-%20final.pdf

This democracy deficit has been social, political, and it's distinctly cultural. The governance culture directed government modelling, communications and public rhetoric in such a way as to systematically absent itself from acknowledging real risk to healthy pregnant women, children and young people from the novel mRNA genetic vaccine. It absented itself from a space to consider that vaccine failure was highly likely when faced with a rapidly transitioning variant, as was expected. Welfare-oriented democratic socialist nations, such as the Nordic nation-states, may have adopted more nuanced approaches to risk. Sweden moved swiftly to signal COVID-19 injections are not required for young children and Norway's cautious stance on adolescent vaccination takes account of adverse event risk.

THE UNACCOUNTABLE LEGAL FRAMEWORK

Data analysis and modelling for the pandemic was located in an institution that was directly funded and overseen by first the Ministry of Business, Innovation and Employment and later, the Department of Premier and Cabinet. The institutions with oversight were the very institutions dedicated to a vaccine roll out. There was no separate, extensively resourced institution with a mandate to explore and report on the science on COVID-19.

There were not only fundamental problems with how research and science was undertaken, but with how the legal framework was set in place. The COVID-19 Public Health Response Bill, the over-riding legislation granting the government to set in place rules and orders throughout the pandemic was introduced on the 12th of May and received Royal Assent on the 13th of May 2020. The Bill, approved overnight, becoming the COVID-19 Public Health Response Act, denied civil society the moment to consider what risk was and how risk should be navigated.

The hastily produced legislation[71] produced after the government had decided on the elimination strategy, prioritised infection rates over public health norms. The legislative purposes established in the COVID-19 Public Health Response Bill, did not demand that public health was protected proportionately across all groups. This removed any government obligation to monitor and report on whether the interventions – lockdowns, mandates, masking and mRNA vaccination, disproportionately harmed a significant part of the population who were *not at risk* from Sars-Cov-2.

Unlike the 1956 Health Act, here was no requirement under the elimination legislation to protect health.[72] The ongoing and sweeping rules and orders that continue to be rolled out, are largely taken under the powers conferred by this Act.[73]

Legislation passed under emergency powers in the latter half of 2021 and throughout 2022 was never accompanied by policy or data that demonstrated that the government had reviewed the published literature on stratification of risk in COVID-19.

The New Zealand public, denied the opportunity to submit earlier, were granted 10 days to Public Health Response Amendment Bill (No 2) in October 2021. The legislation emphasised the prevention of cases over the prevention of hospitalisation and disease. It was evident then that waning was an issue and that there were safety and efficacy problems with the mRNA vaccine. The supporting documents (in the Bills Digest) did not show in any way that the Ardern Government had any grasp of the state of science published in the peer reviewed literature in October 2021. The Ardern Government was dedicated to a public focus on case numbers, and modelling that came from it's own contracted institution, to manufacture consent for ongoing vaccination, regardless of the evidence in the scientific literature.

[71] COVID-19 Public Health Response Bill. Introduced by David Parker. Act: COVID-19 Public Health Response Act 2020 (2020/12) https://www.parliament.nz/en/pb/bills-and-laws/bills-proposed-laws/document/BILL_97739/covid-19-public-health-response-bill
[72] COVID-19 Public Health Response Act 2020 https://www.legislation.govt.nz/act/public/2020/0012/latest/whole.html#LMS344134
[73] PCO (2022). COVID-19 legislation http://www.pco.govt.nz/covid-19-legislation/

The Bills Digest demonstrates that supporting data was at best, severely deficient when the political, social and economic consequences of increasingly hard-line mandates were taken into account.[74] The Regulatory Impact Statement contained no analysis of local or global infection fatality rate, as of September 2021; nor age stratified risk; nor analysis of hospitalisation by case rate in New Zealand; nor analysis of herd immunity present in the population. It was largely ignorant of the state of science at that point in time. There was no analysis of the increasing evidence that adverse events from mRNA genetic vaccines[75] produced disproportionate harm in individuals who were *not at risk* from COVID-19.

The Attorney General stated that the Bill was consistent with the New Zealand Bill of Rights Act 1990. However, the Attorney General, David Parker was *also* the Minister in charge of the parent/original legislation, the COVID-19 Public Health Response Bill.[76] This was a significant conflict of interest that the New Zealand media should have drawn attention to.

The capacity for conflicts of interest to arise across the machinery of government, and for power to be consolidated in relatively few hands, has been recognised in New Zealand for some time.[77]

The courts may have been influenced by the powerful 'case rate' narrative. Uncertainty in judicial decisions veered in support of mandates.[78] [79] [80] [81] In judgements, it appeared that the safety of the novel mRNA technology was inferred, possibly viewed as a similar risk to well established childhood vaccines.

One judgement later shifted to accept a greater appreciation of the risk profile. A February 2022 decision found that the termination of police and defence force personnel for not accepting vaccines was 'not a reasonable limit on their rights demonstrably justified in a free and democratic society in accordance with s5 of the Bill of Rights.'[82] This sort of decision-making had not appeared possible earlier.

Mandates, which required the withholding of rights to unvaccinated citizens would always be a polarizing issue.[83] The curtailment of fundamental human rights and freedoms through the imposition of mandates required that the rules were accepted by the population.

At time of writing, early April 2022 the vaccine pass has been removed and vaccine mandates dropped for the majority of the population, with the exception of health and care workers, prison staff, and border workers.[84]

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[74] COVID-19 Public Health Response Amendment Bill (No 2) 2021: Bills Digest 2656. September 28, 2021. https://www.parliament.nz/en/pb/bills-and-laws/bills-digests/document/53PLLaw26561/covid-19-public-health-response-amendment-bill-no-2-2021

[75] Nakagami, H. (2021). Development of COVID-19 vaccines utilizing gene therapy technology. *International Immunology*, 33:10;521-527. https://doi.org/10.1093/intimm/dxab013

[76] COVID-19 Public Health Response Bill. MP in Charge David Parker. https://www.parliament.nz/en/pb/bills-and-laws/bills-proposed-laws/document/BILL_97739/covid-19-public-health-response-bill

[77] Palmer, G. (1980). *Unbridled Power?* Oxford University Press

[78] Courts of New Zealand (2021, Sept 24). An application for judicial review. Between GF (applicant, a Customs Service worker) and Minister for COVID-19 Response, Associate Minister of Health and the Attorney-General. CIV-2021-485-474 [2021] NZHC 2526. https://www.courtsofnz.govt.nz/assets/cases/2021/2021-NZHC-2526.pdf

[79] Courts of New Zealand (2021, Oct 22). An application for judicial review. Between four aviation security service employees (applicants) and the Minister for COVID-19 Response, Associate Minister of Health and the Attorney-General. CIV-2021-485-509 [2021] NZHC 3012

[80] Courts of New Zealand (2021, Nov 2). An application for judicial review. Between (applicants) four midwives and the Minister for COVID-19 Response and the Attorney General (respondents). CIV-2021-485-584 [2021] NZHC 3064

[81] Courts of New Zealand. COVID-19: Related judgments. https://www.courtsofnz.govt.nz/judgments/covid-19-related-judgments/

[82] High Court of New Zealand (2022, Feb 25). High Court sets aside vaccine mandate for Police and Defence Force. Yardley v Minister for Workplace Relations and Safety https://www.courtsofnz.govt.nz/assets/cases/2022/MR-2022-NZHC-291.pdf

[83] Duch, R. et al. (2021). Citizens from 13 countries share similar preferences for COVID-19 vaccine allocation priorities. *PNAS*, 118, 38,e2026382118. https://doi.org/10.1073/pnas.2026382118

[84] Unite Against COVID-19. (2022, April 4). New Zealand to stay at Red as vaccine passes and most mandates end. https://covid19.govt.nz/news-and-data/latest-news/new-zealand-to-stay-at-red-as-vaccine-passes-and-most-mandates-end/

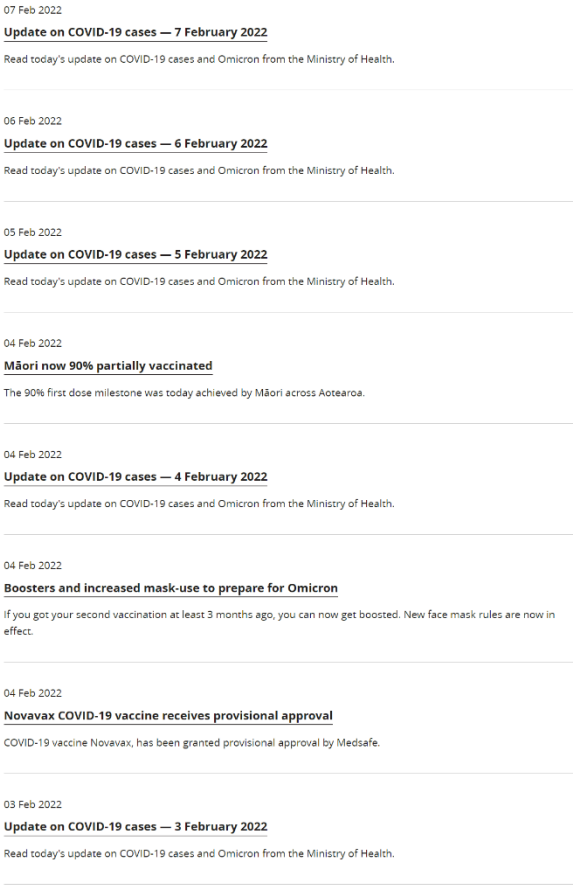
Data from the Ministry of Health appears to demonstrate that at the end of March, hospitalisations in vaccinated and boosted groups were exceeding hospitalisations from unvaccinated groups (stratified to risk per 100,000).[85]

MEDIA CAPTURE

Rights limiting legislation was made possible due to the absence of a safe, robust scientific environment to critic the governments tactics, and was possibly aided by the enormous financial gift provided to New Zealand media from advertising which effectively captured New Zealand media to the COVID-19 campaign narrative. Between 1 March 2021 and 28 February 2022, the Department of Prime Minister and Cabinet's (DPMC) expenditure on vaccine campaign advertising was $35,097,479.[86]

The media's major role was reporting on cases; identifying locations of interest; and reiterating messages from the press briefings, including vaccine and vaccination information.

Media capture 'can be defined as a phenomenon in which 'government or vested interests networked with politics' or 'the rich, special interest groups, political parties, governments, or any actors other than consumers' violate media independence.'[87] Creeping authoritarianism threatens journalism[88] and New Zealand's media landscape was already unstable and financially vulnerable[89] It's well established that advertising expenditure produces a chilling effect on investigatory content that deviates from the advertisers' priorities. In this environment of unprecedented expenditure (the DPMC's total spend between 2014-2019 was under $7 million[90]) the media were unlikely to divert from the government campaign message.


07 Feb 2022
Update on COVID-19 cases — 7 February 2022
Read today's update on COVID-19 cases and Omicron from the Ministry of Health.

06 Feb 2022
Update on COVID-19 cases — 6 February 2022
Read today's update on COVID-19 cases and Omicron from the Ministry of Health.

05 Feb 2022
Update on COVID-19 cases — 5 February 2022
Read today's update on COVID-19 cases and Omicron from the Ministry of Health.

04 Feb 2022
Māori now 90% partially vaccinated
The 90% first dose milestone was today achieved by Māori across Aotearoa.

04 Feb 2022
Update on COVID-19 cases — 4 February 2022
Read today's update on COVID-19 cases and Omicron from the Ministry of Health.

04 Feb 2022
Boosters and increased mask-use to prepare for Omicron
If you got your second vaccination at least 3 months ago, you can now get boosted. New face mask rules are now in effect.

04 Feb 2022
Novavax COVID-19 vaccine receives provisional approval
COVID-19 vaccine Novavax, has been granted provisional approval by Medsafe.

03 Feb 2022
Update on COVID-19 cases — 3 February 2022
Read today's update on COVID-19 cases and Omicron from the Ministry of Health.

Image. Case Numbers, masking & vaccination dominate New Zealand Unite Against COVID-19 communications

The facts suggest that consent for lockdowns and mandates were manufactured through the constant repetitive promotion of case locations, and the promotion of ongoing societal ignorance regarding age and health stratified risk.

All citizens over the age of 12 were required to accept an injection with a novel mRNA technology in order to participate in economic and social life. The implications of the legislation were to dispense with the historic principle of informed consent. The principle of 'first do no harm' is intimately tied to the principle of informed consent, which recognises patients' rights to personal autonomy and freedom of choice. In order to protect the individual and ensure the patient-doctor relationship is not abused, medical practitioners have a professional and ethical responsibility to ensure patients can 'realistically and objectively balance the risks

[85] Dixon, G. (2022, April 3). Why vaccinated nurses & doctors should be mandated. https://www.youtube.com/watch?v=xWq2iCnqqvg
[86] Boswell, R. (2022, Mar 27). Govt's Covid advertising tips past $35M in last year alone. https://www.1news.co.nz/2022/03/27/govts-covid-advertising-tips-past-35m-in-last-year-alone/
[87] Choi JP & Yang S. (2021). Investigative journalism and media capture in the digital age. *Information Economics and Policy*, 57, 100942.
[88] Wiersma, C. (2020) The 'Disobedience' of Journalists at Public Assemblies: An Analytical Critique of the ECtHR's Case Law from a Media Freedom Perspective, *Nordic Journal of Human Rights*, 38:4, 261-278, DOI: 10.1080/18918131.2021.1907949
[89] Ellis, G. (2016, May) Restoring Civic Values to the News Media Ecology. *Policy Quarterly*, 12, 2..
[90] DPMC (2019, Mar 13). Advertising spend by DPMC OIA-2018/19-0402 https://dpmc.govt.nz/sites/default/files/2019-04/dpmc-roiar-oia-2018-19-0402-advertising-costs-2014to2019.pdf.pdf

and benefits of a proposed course of care'.[91] Informed consent allows for the fact that all medication carries some risk, and this ensures that those who may be more at risk from a side effect from a medication than a benefit from that medication, will not be exposed to it.

Situating a single medicine as the single most important individual action similarly violated the longstanding principles of infectious disease enshrined in the Health Act, including proportionality.[92]

The science and modelling trajectory simply didn't make a space to permit unwelcome data which might draw attention to the fact that the mRNA technology was not required by most members of the population, and that it might instead harm those who were not at risk. This was not a conventionally safe medication, it was a novel technology that had skipped most of its clinical trial requirements, and for which no genotoxicity or carcinogenicity data was required to be produced. The human rights issues that arise from the deficient policies and laws, are directly related to the narrow focus of experts who were picked to participate in the COVID-19 campaign.

The actors that sought to challenge the narrative, interdisciplinary groups such as Plan B[93], New Zealand Doctors Speaking Out with Science (NZDSOS)[94] and Voices for Freedom[95] and Guy Hatchard[96] have had to rely on their own websites, small independent news sites and sharing on social media. The line dividing what Prime Minister Ardern has referred to as the 'accredited media'[97] and the news sites that carry content from these groups - who have struggled to provide a counter-narrative to claims about vaccine safety and efficacy, and the role of natural or herd immunity, and the legitimacy of mandates - may be the degree of funding from the New Zealand state.

THE VACCINE WAS NEVER A SILVER BULLET

The post-October 2021 onwards enforcement measures, were implemented to increase vaccine take-up *at the very time* the scientific literature was robustly questioning the safety and efficacy of the mRNA vaccine. From mid-2021 it had become evident that the New Zealand Government's approach was ethically unjustified because it could not reflect age and health status stratified risk. However, these issues were never publicly discussed and attempts to open dialogue about these issues were subjected to heavy censorship on multiple mainstream and social media platforms.

Public understanding of risk is distinctly embedded in historical and cultural contexts. And 'public ignorance is not simply a passive neglect of science. Rather, it is an active social construction used to deal with potentially dangerous, conflicting, or uncertain knowledge.'[98]

In April 2021 scientists were drawing attention to the limited efficacy of the BNT162b2 against new variants.[99] The literature suggesting that mRNA vaccines would have limited efficacy against Omicron is, at time of writing, over 2 months old.[100] [101] The heavily mutated Omicron variant contained over 30 mutations on the spike protein, and as the spike protein is the key protein in the mRNA genetic vaccines, it was likely

[91] Roe, A.M. (2009). Not-So-Informed Consent: Using the Doctor Patient Relationship to Promote State-Supported Outcomes. 60 Case W. Rsrv. L. Rev. 205. https://scholarlycommons.law.case.edu/caselrev/vol60/iss1/7/
[92] PCO. Health Act 1956. Part 3A Management of infectious diseases. 92A Principles to be taken into account
[93] COVID Plan B. https://www.covidplanb.co.nz/
[94] New Zealand Doctors Speaking Out With Science https://nzdsos.com/
[95] Voices for Freedom. https://www.voicesforfreedom.co.nz/
[96] Guy Hatchard. HatchardReport.com
[97] Wei, X. (2021, Nov 2). Jacinda Ardern abruptly ends press conference as she dodges 'non-accredited' questions. https://www.express.co.uk/news/world/1515226/Jacinda-Ardern-news-press-conference-coronavirus-vaccine-New-Zealand-video-vn
[98] Garvin, T. (2001). Analytical Paradigms: The Epistemological Distances between Scientists, Policy Makers, and the Public. *Risk Analysis*, 21, 3, https://doi.org/443-455. 10.1111/0272-4332.213124
[99] Kuzmina, A. et al 2021. SARS-CoV-2 spike variants exhibit differential infectivity and neutralization resistance to convalescent or post-vaccination sera. *Cell Host & Microbe.* 29,522-528. https://doi.org/10.1016/j.chom.2021.03.008
[100] Liu L. et al. (2021). Striking antibody evasion manifested by the Omicron variant of SARS-CoV-2. *Nature,* 602, 676-681 t https://doi.org/10.1038/s41586-021-04388-0.
[101] Planas et al. (2021). Considerable escape of SARS-CoV-2 Omicron to antibody neutralization. *Nature*, 602, 671-675. https://doi.org/10.1038/s41586-021-04389-z

the variant would evade vaccine induced immunity.[102] It is increasingly clear that mRNA vaccination produces a short protective effect for Omicron and its variants (sub-lineages).[103] [104] [105] Omicron appears less harmful, has a milder course in most people, doesn't appear to bind to the lungs, as was seen with Delta, and does not result in the same level of clotting.[106] [107] Yet still the healthy population have been urged to get boostered.

Coronaviruses mutate readily, and early treatment protocols would enable the health sector to navigate around an out-of-date vaccine. As Omicron replicates in the nasal passage, preventative treatments targeting nasal replication may be more effective. Boosters remain targeted to the 2020 virus.

On the 23rd of March Prime Minister Ardern announced that requirements for outdoor gathering limits, QR codes would cease. Vaccine mandates would cease for police, education, defence and businesses that currently use vaccine passes. This decision was taken as 20,000 new community cases were recorded.[108]

Therefore, until April 4, 2022 New Zealanders rights remained restricted, and behaviour monitored. All students in secondary and tertiary institutions were required to wear a mask for all learning activities despite Omicron having travelled through all schools and universities at speed from the start of the new term.

Without science to legitimate controversies, questions of an acceptable level of risk are brought into debates, and the claims can remain at large, unless addressed by the courts. Yet if officials wait for the courts to decide all our controversies, Aotearoa New Zealand will eternally lag in health and in regulation. It often takes years to prove a 'harm'. Jonathan Boston has 'argued that the inputs into advice need to be open and transparent and allow for points of difference and disagreement.'[109]

This is of course the issue – science is subject to all the vagaries of power, culture and predeterminism – we must make a safe space for controversy in discussion, in science policy – as with public policy.

Civil society cannot leave science to the scientists, particularly when policies deflect science away from uncomfortable knowledge critical for informed policy. Current policies have left research and science precarious and short term, this is the opposite of what is required in the Anthropocene. Risk governance cannot be simple as technocratic government messaging urging the population to blindly accept a novel entity - because risk governance is multifactorial, involving the intersection of institutional (political and financial) power and human, environmental and democratic health. Human and environmental health will always be uncertain and controversial because risk for situation or person A is endlessly different than risk for situation or person B. In such a place, the public requires values and judgement, rather than dictatorship.

The democratic deficits have been observed in overseas jurisdictions. many of whom the have been relied on. The safety and efficacy claims of powerful offshore institutions, have increasingly been found to have concerning conflicts of interest.[110] Robert F. Kennedy Jr. has stated:

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[102] Araf, Y. et al (2022). Omicron variant of SARS-CoV-2: Genomics, transmissibility, and responses to current COVID-19 vaccines. *Hournal of Medical Virology,* 94,5 1825-1832. https://doi.org/10.1002/jmv.27588
[103] Gov.Uk (2022, Jan 28) COVID-19 variants identified in the UK. https://www.gov.uk/government/news/covid-19-variants-identified-in-the-uk
[104] Dorabawila V., et al. (2022). Effectiveness of the BNT162b2 vaccine among children 5-11 and 12-17 years in New York after the Emergence of the Omicron Variant. medRxiv. https://doi.org/10.1101/2022.02.25.22271454 Posted February 28,2022.
[105] Andrews et al. (2022). Covid-19 Vaccine Effectiveness against the Omicron (B.1.1.529) Variant. NEJM, https://doi.org/10.1056/NEJMoa2119451
[106] Lewnard, J.A. et al. (2022). Clinical outcomes among patients infected with Omicron (B.1.1.529) SARS-CoV-2 variant in southern California. *medRxiv preprint,* https://doi.org/10.1101/2022.01.11.22269045
[107] Ulloa, A.C. et al. (2021). Early estimates of SARS-CoV-2 Omicron variant severity based on a matched cohort study, Ontario, Canada. *medRxiv preprint.* https://doi.org/10.1101/2021.12.24.21268382
[108] Ensor J. (2022, March 23). Coronavirus: Latest on COVID-19 community outbreak - Wednesday, March 23 https://www.newshub.co.nz/home/new-zealand/2022/03/coronavirus-latest-on-covid-19-community-outbreak-wednesday-march-23.html
[109] Jeffares, B. et al. (2019) Science Advice in New Zealand opportunities for development. *Policy Quarterly,* 15, 2 May 2019.
[110] Kennedy Jr, R.F.. The Real Antony Fauci.

> 'The shockingly low quality of virtually all relevant data pertinent to COVID-19, and the quackery, obfuscation, the cherry picking and blatant perversion would have scandalized, offended and humiliated every prior generation of American public health officials. Too often, Dr. Fauci was at the centre of these systemic deceptions. The 'mistakes' were always in the same direction – inflating the risks of coronavirus and the safety and efficacy of vaccines in order to stoke public fear of COVID and provoke mass compliance.' P.5[111]

Good science should not have financial conflicts of interest, and as Jeffares et al. (2019)[112] have noted

> Science should be open to scrutiny and review, and a necessary (but not sufficient) condition for robust science is transparency, which enables the detection of errors: methodological errors, unwarranted assumptions, bias and straightforward mistakes. Science might not be free of bias, but the culture of practice within science, at its best, is one of verification and robust critique of the claims of others. The need for scrutiny by others motivates the practice of peer review, but the need for scrutiny does not end with a scientist's peers; it requires diverse views to be brought to bear from different standpoints and positions. Viewing a problem through different lenses sheds light on new solutions.

Going on to add

> 'Therefore, in the policy context, in order to ensure that science advice is based on robust science there is a need to ensure scrutiny of this science, via peer review and more, from diverse perspectives.

Health equity and pandemic resilience beyond 2022 will not be achieved by routine global vaccination which rests on some sort of utilitarian techno-utopian ideology.

There must be a safe space to critique the COVID-19 campaign, as the campaign may have resulted in more deaths than a strategy of focussed protection. From March until October 2021, when the bulk of the mRNA genetic vaccine rollout occurred, all-cause mortality rose in New Zealand. [113] All-cause mortality has been an important signalling device for population level risk, providing an estimate of population-level harm[114][115] particularly as, in the clinical trials, deaths in the mRNA vaccinated group were higher than in the placebo group.[116] A cohort of Canadian doctors have drawn attention to the fact that the clinical trials did not have a clinical end point of prevention of illness and death.[117] [118] The under-reporting of medicine-related (iatrogenic) harm or death is an unfortunate legacy of voluntary reporting systems.[119] Of course, it all-cause mortality does not solely arise from vaccine-related harm, is associated with isolation and lockdown policies, and socially vulnerable, and economically precarious groups are most likely to be at risk.[120] [121]

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[111] Kennedy Jr, R.F.. The Real Antony Fauci.
[112] Jeffares, B. et al. (2019) Science Advice in New Zealand opportunities for development. *Policy Quarterly,* 15, 2 May 2019.
[113] New Zealand Lawyers Speaking Out with Science. (2022, Mar 22). Open letter to the police Commissioner and request for a meeting. https://nzdsos.com/2022/03/17/nzlsos-open-letter-to-police-commissioner/
[114] Neil et al 2021. Discrepancies and inconsistencies in UK Government datasets compromise accuracy of mortality rate comparisons between vaccinated and unvaccinated. Queen Mary, University of London, UK 27 October 2021
[115] Pantazatos SP & Seligman H. (Supplementary Material for "COVID-19 vaccination and age-stratified all-cause mortality"
[116] Vaccines and Related Biological Products Committee (VRBPAC) (2021, Nov 8). Summary Basis for Regulatory Action https://www.fda.gov/media/151733/download
[117] Canadian Covid Care Alliance (2021, Dec 16). The Pfizer Inoculations Do More Harm Than Good. https://rumble.com/vqx3kb-the-pfizer-inoculations-do-more-harm-than-good.html
[118] Canadian Covid Care Alliance (2022, Feb 1). Dispelling the Myth of A Pandemic of the Unvaccinated https://rumble.com/vtt9ge-dispelling-the-myth-of-a-pandemic-of-the-unvaccinated.html
[119] Lazarus R, Klompas M. Electronic Support for Public Health–Vaccine Adverse Event Reporting System (ESP:VAERS) [Internet]. Available from: https://digital.ahrq.gov/sites/default/files/docs/publication/r18hs017045-lazarus-final-report-2011.pdf
[120] Motairek, I. et al (2022). Social Vulnerability and Excess Mortality in the COVID-19 Era. *The American Journal of Cardiology.* https://doi.org/10.1016/j.amjcard.2022.03.011
[121] Joffe AR (2021) COVID-19: Rethinking the Lockdown Groupthink. *Front. Public Health* 9, 625778 https://doi.org/10.3389/fpubh.2021.625778

Health equity and pandemic resilience will be achieved by prioritising value-lead decision-making to ensure public servants and politicians appropriately judge health intergenerational risk. By resourcing independent science, that as knowledge, can inform judgement and guide policy. Central to health equity is equity of social and economic health and the promotion of autonomy and individual agency. Private global institutions persistently fail to iterate human rights, autonomy and human agency in their future visions for ongoing surveillance and future vaccine development. These large institutions operate outside democratic states, while exercising an undue influence on these same states, far in excess of the influence of citizens. Vaccine mandates potentially create cascading harm across society, reducing trust and promoting polarisation:

> 'Restricting people's access to work, education, public transport, and social life based on COVID-19 vaccination status impinges on human rights, promotes stigma and social polarization, and adversely affects health and wellbeing. Mandating vaccination is one of the most powerful interventions in public health and should be used sparingly and carefully to uphold ethical norms and trust in scientific institutions. We argue that current COVID-19 vaccine policies should be reevaluated in light of negative consequences that may outweigh benefits. Leveraging empowering strategies based on trust and public consultation represent a more sustainable approach for protecting those at highest risk of COVID-19 morbidity and mortality and the health and wellbeing of the public.'[122]

In Aotearoa New Zealand, once the campaign and case narrative commenced, the funding was directed to media, there was no safe place to bring more complex issues into a public forum.

The urgency of reinserting democratic values of protection of civil society across the machinery of government is critical that society develops mechanisms to ensure the production of uncomfortable – and often highly political – knowledge. Wicked problems are never neatly resolved, they are untangled, and the degree to which they are untangled depends on how far policy, the researcher, the science and the public are able to track upstream to understand the drivers of the harm and verify the safety and efficacy claims of the technology producers.[123] As research and science is expensive to produce, governments have a direct responsibility in making a safe space for this interdisciplinary work.

Such mechanisms enable groups of experts and the public to consider how democratic societies might act with precaution, in order to regulate and prevent harm occurring that might be beyond the capacity of a biological system – from a child to a young man – to tolerate.

4: IN A CONTROVERSY, WHO CONTROLS THE SCIENCE? (AKA THE MODELLING)

From the early days, the narrative of control was focussed on prevention of transmission, rather than a narrative of care. Professor A.C. Grayling has drawn attention to an inevitable issue that will always plague democracies, 'all human institution can be 'gamed' or manipulated in the interests of those with greatest access to the machinery of those institutions.' [124]

Many governments keep research and science institutions stand alone or connected to the education sector. the majority of science funding in New Zealand is directed through the Ministry for Business, Innovation and Employment. Overarching science policy directs New Zealand's research, science and innovation system to prioritise excellence, investment return and the production of innovation (patents are a proxy for GDP). Since the advent of national systems of innovation some twenty years ago[125], New Zealand's research and science communities, their expertise and cultures of decision-making relating to science production, have adjusted to

[122] Bardosh, K. et al The Unintended Consequences of COVID-19 Vaccine Policy: Why Mandates, Passports, and Segregated Lockdowns May Cause more Harm than Good. https://ssrn.com/abstract=4022798
[123] Rittel, H., & Webber, M. (1973). Dilemmas in a general theory of planning. Policy Sciences, 4(2), 155-69.
[124] Grayling, A.C. (2017). *Democracy and its Crisis.* Oneworld Publications. P.203
[125] Leitch, S., & Davenport, S. (2005). The politics of discourse: Marketization of the New Zealand science and innovation system. Human Relations, 891-912. https://doi.org/10.1177/0018726705057810

Ministry directed expectations that prioritise innovation.[126] Science policy has produced funding cultures which find it easier to finance technical research which might result in the development of an innovation (a product, process, good or service).

Funding environments are ultracompetitive, and unconventional or non-normative scientific research outside norms of scientific excellence such as complex, interdisciplinary work is more difficult to secure. Current and legacy policies have resulted in directing knowledge production towards digital technologies, biomedical science and genetics, which might promote economic growth through business development, and away from science that untangles the drivers of health and disease in humans, and in ecological systems.

WE DON'T DO BAD NEWS ON TECH

It is very unlikely a researcher or scientist in Aotearoa New Zealand will draw attention to the adverse effect of modern technologies. New Zealand's research and science system cannot help but be techno-optimistic, as there is no safe place to research or produce science that might explore the adverse effects of novel technologies (also known as novel-entities) including pharmaceuticals and genetically engineered products. The current institutional structures make it enormously difficult to weigh the benefits of public health research when exciting economic drivers such as prospective returns from medicine and biotechnologies divert research funding away from uncomfortable knowledges. When it comes to human technologies and pollutants that harm our heart, our endocrine system or contribute to cancer risk, the harm can arise before conception, during gestation, and childhood. This harm in vulnerable developmental periods can lead to neurological delays and greater predisposition to disease decades later. But we don't actually know how to navigate these uncertainties in New Zealand, and to a very big degree, we don't talk about them.

Over this time, health research in the physical sciences has been shepherded towards biomedical research that is translatable inside the health sector. For scientists on the ground, this means that realistically, funding will come if they propose scientific research that has a biomedical application. Over this 20 year period, the institution of health research in New Zealand has become predominantly medicalised. This has acted as a feedback loop into the policy and medical community. It's meant that it has been enormously difficult to draw attention to the drivers of human health risk. In New Zealand, our predominant illnesses are obesity, and obesity related metabolic disease, which crosses into cardiac-related health risk. It's now very, very clear that environment drives health and disease, not genetics or access to medicine.

The capacity of the science system to inform relevant Ministries and regulatory authorities, and guide policy to make important decisions to protect and promote health, is decoupled, because the science funding system still looks at funding by individual disease, and doesn't make it easy for physical scientists to get funding to look upstream at the drivers of disease.

A failure to address the environmental drivers of disease, not only increases risk for non-communicable diseases – but increases risk from communicable diseases including Covid-19. One of the many reasons, is that people with obesity and metabolic diseases have greater levels of inflammation in their body, and the bodies efforts to mediate that inflammation, mean that their nutritional and biological resources are used up doing this job, and there are less resourced available to fight early stage infection, and prevent, for example, a respiratory virus descending into the lower respiratory tract, and the consequent cascade of pathological conditions observed, when early treatment doesn't address Covid-19 at an early stage. Unfortunately, no data scientists are engaged to explore the costs of nutritional deficiencies in childhood, risk for obesity, or the problem of polypharmacy in our multimorbid populations and tasked to track the costs at the individual and societal level.

[126] MBIE (2015 Oct). National Statement of Science Investment. https://www.mbie.govt.nz/assets/2eaba48268/national-statementscience-investment-2015-2025.pdf

Innovation mindsets might encourage cultures less suited to coping with socio-biological ethical dilemmas including the right to deny a medical intervention[127], particularly from a novel mRNA gene technology. Vaccination rates are established as a high-level health system indicator by the Ministry of Health.[128] The system (which in 2020 replaced health targets) focusses on hospitalisation and medical treatment rather than, for example, reduction of obesity or mental illness.

However, when vaccination is a high-level indicator, the practice of vaccination is unlikely to be critically reviewed, even if a product is vastly different to existing vaccines. Criticism of all technology must be permitted if the public are to not just economically, but socially and culturally benefit. If public servants and citizens cannot criticise technology, any promise of wellbeing cannot be fulfilled. Vaccines are a fundamentally unsafe technology; they involve the injection of an antigen into a body. This is why vaccine manufacturers are indemnified.

AOTEAROA NEW ZEALAND'S COVID-19 SCIENCE ENVIRONMENT

When COVID-19 arrived, the government did not encourage a quorum of interdisciplinary experts with expertise in ethics, law, biology, medicine and epidemiology and public health to come together and transparently with differing perspectives and thrash out the ethical socio-legal issues around out in a safe forum – to understand how risk would be managed and evaluate the ethical implications of prospective measures.

Instead of data production in a school of public health, data production, or modelling was delegated to a institution lacking a culture and appreciation of the principles of public health. This continues in March 2022.

The case focus has dominated and captured how the risk was modelled, communicated and promoted for the following two years. This approach has sidelined important established principles of public health which reflects issues of rights and protection. Case or infection rate modelling, and to a much, much lesser extent, modelling of hospitalisation and death has been the process by which the Ardern government, contracted institutions and a few key elites have manufactured consent for policy measures driving the population towards surveillance and ongoing vaccination. In a government that claims to use science for evidence-based decisions, there has been a consistent and ethically problematic absence of literature reviews and discussion of the peer reviewed literature.

The age and health stratified risk status have predominantly remained outside public deliberation for the duration of the pandemic. From the very first moments, the public narrative on COVID-19 risk was structured around the idea that 100% of the population were susceptible to Covid-19 ensuring a focus on around prevention of cases, not of hospitalisation and death. [129] This locked in a narrative of control of a respiratory virus, rather than population level protection of hospitalisation and death.

From the very start, risk was weighted towards older adults. One of the early modelling papers recognised that that perhaps 88.9% of deaths would occur in the 60 plus age group.[130] Exactly two years later, 81% (or 35 out of 43) of the Covid-19 caused deaths are in the 60 plus category.[131]

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[127] The Nuremberg Code (1947) https://media.tghn.org/medialibrary/2011/04/BMJ_No_7070_Volume_313_The_Nuremberg_Code.pdf

[128] Health System Indicators framework https://www.health.govt.nz/new-zealand-health-system/health-system-indicators-framework

[129] Ministry of Health (2020, March, 30). Background and overview of approaches to COVID-19 pandemic control in Aotearoa/New Zealand. Prepared by the COVID-19 Public Health Response Strategy Team https://www.health.govt.nz/system/files/documents/publications/background-overview-approaches-covid-19-pandemic-contro-aotearoa-new-zealand-30mar20.pdf

[130] Wilson et al (2020, March 23). Potential Health Impacts from the COVID-19 Pandemic for New Zealand if Eradication Fails: Report to the NZ Ministry of Health. COVID-19 Research Group University of Otago Wellington. https://www.health.govt.nz/system/files/documents/publications/report_for_moh_-_covid-19_pandemic_nz_final.pdf

[131] MoH (2022, March 29). Covid-19 Case Demographics. https://www.health.govt.nz/covid-19-novel-coronavirus/covid-19-data-and-statistics/covid-19-case-demographics#deaths

The Department of Prime Minister and Cabinet has directed funding to understand risk in the COVID-19 pandemic. The COVID-19 business unit was established within the Department of Prime Minister and Cabinet. This unit was not only responsible for strategy and policy, operational co-ordination and public communications, it was established as the data hub,

> **Data analytics, monitoring, reporting and insights -** including coordinated reporting to provide a tested, robust and consistent source of information, and provide agencies with cross government developed modelling and operational trends.[132]

While initially funded by the MBIE, the Department of Prime Minister and Cabinet currently directly fund and contract the University of Auckland based institution Te Pūnaha Matatini and the COVID-19 Modelling Aotearoa cohort. [133] [134] Te Pūnaha Matatini, is not an institute with experience in infectious disease epidemiology nor does it exercise an appreciation of the long standing principles of public health, which have traditionally been incorporated into infectious disease modelling and planning strategies.

Te Pūnaha Matatini was established to explore and understand complex systems and uncertainty. COVID-19 work appears to be centred around conducting modelling using data supplied directly from officials. Their Sars-Cov-2 modelling has failed to take account of open-ended dilemmas inherent in risk modelling: complexity, uncertainty and ambiguity.

Astonishingly, the vast majority of modelling was not directed to infectious disease epidemiologists, who historically recognise a wide range of factors that are relevant to understanding public health risk, including the requirement that responses are proportionate to the risk. This includes the role of herd immunity and the potential for susceptible hosts to be most at risk and the potential for animals, soil and water to act as reservoirs. Infectious disease epidemiologists recognise the role of pre-existing conditions for increasing risk from infection.[135] These issues were not considered in Te Pūnaha Matatini modelling.

Experts in epidemiology appeared to perform early minor roles in assessing risk throughout the pandemic, and they clearly drew attention to age stratified risk. [136] [137] However, with the exception of Professor Michael Baker, who authored a couple of studies, the majority of work has been carried out by mathematical and data modellers.

Perhaps only 3 out of some 50 experts involved in modelling and policy appeared to be epidemiologists. New Zealand's Covid-19 Technical Advisory Group did include one infectious disease epidemiologist, Professor Michael Baker.[138] The Covid-19 Modelling Aotearoa team were comprised of mathematicians, and data analysts. No experts in public health appeared to have a leading role in any of this modelling. The team were distinguished by an *absence* of public epidemiologists. [139]

Te Pūnaha Matatini have had two roles – modelling risk,[140] and a second, known as The Disinformation Project, which is engaged to observe, track and analyse: 'open source, publicly available data related to

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[132] Department of the Prime Minister and Cabinet (2020, Jul 1). New COVID-19 business unit for DPMC https://dpmc.govt.nz/news/new-covid-19-business-unit-dpmc
[133] University of Auckland. About Covid-19 Modelling Aotearoa. https://www.covid19modelling.ac.nz/about/
[134] Te Pūnaha Matatini COVID-19 Modelling Aotearoa https://www.tepunahamatatini.ac.nz/covid-19/
[135] Straif-Bourgeois S. et al. (2014). Infectious Disease Epidemiology. Ch.51. Handbook of Epidemiology, 2nd edition, W. Ahrens, I. Pigeot (eds.)
[136] Wilson et al (2020, March 23). Potential Health Impacts from the COVID-19 Pandemic for New Zealand if Eradication Fails: Report to the NZ Ministry of Health. COVID-19 Research Group University of Otago Wellington. https://www.health.govt.nz/system/files/documents/publications/report_for_moh_-_covid-19_pandemic_nz_final.pdf
[137] Baker, M.G. et al. (2020, Apr 3) Editorial: NZMJ New Zealand's elimination strategy for the COVID-19 pandemic and what is required to make it work. *The New Zealand Medical Journal*, 133(1512), PMID: 32242173 https://journal.nzma.org.nz/journal-articles/new-zealands-elimination-strategy-for-the-covid-19-pandemic-and-what-is-required-to-make-it-work
[138] MoH (2021, June 2). COVID-19 Technical Advisory Group. https://www.health.govt.nz/about-ministry/leadership-ministry/expert-groups/covid-19-technical-advisory-group
[139] University of Auckland. About Covid-19 Modelling Aotearoa. https://www.covid19modelling.ac.nz/about/
[140] University of Auckland. About Covid-19 Modelling Aotearoa. https://www.covid19modelling.ac.nz/about/

Covid-19 mis- and disinformation on social media, mainstream media, and in physical and other digital forms of information and knowledge dissemination.'[141]

While a tumult of modelling papers have been released, we have not seen the release of literature reviews on new knowledge relating to the safety and efficacy of Comirnity, also known as research name BNT162b2. It is evident that the COVID Vaccine Technical Advisory Group was not particularly interested in a feedback loop from Medsafe, that might have highlighted safety and efficacy concerns.[142]

Reviews could have updated the public on the scientific evidence on waning, the risk profile of the spike protein, the potential for early treatment to be a tool when efficacy declines with new variants, and the risk-benefit profile by age and health status. This sort of research and science has not been undertaken.

Has the science engaged by the state conformed to norms of accountability and transparency, and norms of public health, including the principle of proportionality, the principle of first do not harm, and the principle of informed consent. The world is not very good at stewarding manmade inventions.[143] We don't provide a safe space for uncomfortable knowledges that might disrupt institutional activities. We're not very good at funding science that particularly, draws attention to the social and environmental determinants of health and disease in childhood. The one institution that might have addressed this, Gravida, was defunded. Other institutions in this space prefer to discuss personal behavioural modalities, but don't fund research that might impact economic activity. Because we are less likely to fund this science, it is then very difficult for the few institutional experts left, to speak up against the weight of institutional opinion.

5: CASE RATE RHETORIC: WERE THE PUBLIC BEEN KEPT IN THE DARK?

The earliest publications which came out of the Ministry of Health were built on an elimination of all cases rhetoric, by April 2020 elimination was established as the campaign mode. Press releases listed all cases and emphasised on a daily basis, the acceleration and location of cases, and for many months. Because of the stigma of being a 'case' there was population level shame attributed to involvement in the case location. The legislation that has driven New Zealand's hard-line mandates have been based on elimination strategies which necessitated high vaccination rates, in order to 'eliminate' the cases.

From the earliest, most of the population were not at risk of hospitalisation and death, but the case rate rhetoric did not provide a safe space for people to question whether a case was a 'good' thing. In line with longstanding principles of epidemiology, each case would shift the population (or herd) closer to immunity, and as natural immunity increased, the virus would become less harmful. According to established principles of epidemiology, most of the population could safely become infected, and therefore the most important tactics were to protect the vulnerable. However, this was never a conversation that was undertaken in a public forum. This strategy of case alarm, or case fear, promoted ignorance in the population.

Yet one of the most senior scientists involved in the campaign, David Skegg, considered in June 2021 that the mRNA provided better immunity than from natural infection.[144] The discounting of the role of natural immunity provides some clue as to the priorities of the modellers and scientists, throughout the 2 years to 2022.

It was known from very early stages that there was a1000-fold difference in risk of death for those over 65, compared to children and young people (CYP). Most New Zealanders were not at serious risk from COVID-

[141] Hannah, K. et al. (2021, Nov 9).Working Paper: Mis- and disinformation in Aotearoa New Zealand.
[142] Medsafe (2021, Oct 6). Response to your request for official information H202111774 https://fyi.org.nz/request/16608/response/64249/attach/4/H202111774%20S.Brown%20response.pdf
[143] Persson, L., (2022) Outside the Safe Operating Space of the Planetary Boundary for Novel Entities. Env. Sci. Technol.
[144] Skegg Review (2021). Letter to Hon Ayesha Verrall. Strategic COVID-19 Public Health Advisory Group.

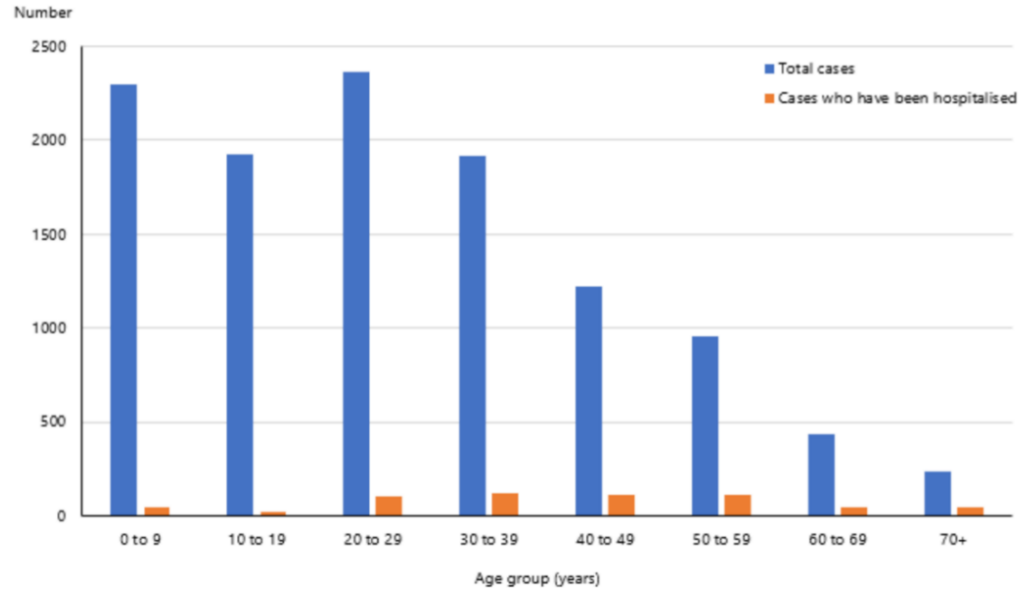
19, and the relatively low infection fatality rate early on in the pandemic, with risk stratified by age.[145] [146] [147] As with the general population, pregnant women were not at risk of hospitalisation and death unless morbidly obese and with significant complicating factors.[148] [149]

Focussed protection is a fundamental norm of public health, as it aims to protect the vulnerable while permitting not-at risk groups to go about daily life. Early in the pandemic the Great Barrington Declaration[150] (and others[151]) recommended protection of high risk and vulnerable groups to prevent the public health harms of lockdowns where negative consequences may 'outweigh benefits'.[152]

It is unlikely that the majority of the population would have considered that they were *not* at risk of hospitalisation or death, based on the Ardern Governments to all appearances, misleading promotional Unite Against COVID-19 Campaign.

A January 2022 Ministry of Health chart shows the frequency of hospitalisation following Sars-Cov-2 infection by age group. Hospitalisations were few, and this was in the period when Delta, which was recognised to potentially lead to more hospitalisations and death than Omicron, was the predominant infectious strain. It's unlikely most of the population would have recognised their risk profile by age group.

Figure 5.2: Total COVID-19 cases and hospitalised COVID-19 cases by age group in New Zealand, August 2021 to 18 January ~~2021~~. (18 January 2022)



Source: Ministry of Health New Zealand Immunisation Handbook. Updated January 2022 by the Ministry of Health. Page 156

[145] Ioannidis, J.P. et al. (2020). Population-level COVID-19 mortality risk for non-elderly individuals overall and for non-elderly individuals without underlying diseases in pandemic epicenters, *Environ Res.*, 188, 109890. https://doi.org/10.1016/j.envres.2020.109890
[146] Ioannidis, J.P. (2021). Infection fatality rate of COVID-19 inferred from seroprevalence data. *Bull World Health Organ.* 99(1), 19-33F. http://dx.doi.org/10.2471/BLT.20.265892
[147] Axfors, C. and Ioannidis P.A. (2021) Infection fatality rate of COVID-19 in community-dwelling populations.
[148] Vousden, N. et al (2021). Impact of SARS-CoV-2 variant on the severity of maternal infection and perinatal outcomes: Data from the UK Obstetric Surveillance System national cohort. *medRxiv preprint* https://doi.org/10.1101/2021.07.22.21261000
[149] Dagan, N. et al. (2021). Brief Communication: Effectiveness of the BNT162b2 mRNA COVID-19 vaccine in pregnancy. *Nature Medicine.* 27, 1693-1695. https://doi.org/10.1038/s41591-021-01490-8
[150] Great Barrington Declaration https://gbdeclaration.org/
[151] Halperin, D.T. et al. (2021). Revisiting COVID-19 policies: 10 evidence-based recommendations for where to go from here. *BMC Public Health*, 21:2084. https://doi.org/10.1186/s12889-021-12082-z
[152] Bardosh, K. et al. (2022). The Unintended Consequences of COVID-19 Vaccine Policy: Why Mandates, Passports, and Segregated Lockdowns May Cause more Harm than Good. https://dx.doi.org/10.2139/ssrn.4022798

The Unite Campaign produced, instead of a broader, balanced perspective, which evaluated risk by age, a tendency across the nation of uniformly (and breathlessly) ascribing equivalent risk to all case numbers. In the two years between February 15, 2020, and January 29, 2022, a total of 18,000 cases were reported and 53 deaths, directly attributed to COVID-19 occurred.[153] The case rate narrative appeared to smooth the way for the Ardern Government to impose the case focussed stamp it out, [154] elimination strategy, 'Red' Traffic Light restrictions; implement and maintain onerous and ethically problematic, mandate restrictions. The Unite Campaign continue to promote fear of case numbers, and urge vaccination, even as the scientific literature suggested global vaccination was neither safe, nor effective, and could not prevent 'cases'. The traffic light system unashamedly privileged those with a current vaccine pass.[155] Government pressure did not lessen with the arrival of Omicron variant.

The traffic light system was designed to 'nudge people towards vaccination'.[156] Constant promotion of case numbers and highlighting of places of interest through surveillance and contact tracing strategies, is an element of the behaviour modification nudge science. The nudge strategy was applied to drive the entire population towards isolation and vaccination, rather focussed protection for vulnerable groups.

Risk stratified by age and health status was not a key message in government communications, instead, daily messaging concerned the seriousness of 'the case', without drawing attention to personal risk. With sustained ignorance relating to the infection fatality rate, fear in the population of COVID-19 was likely to be over-estimated, particularly from mid-2021 when the infection fatality rate was established in the scientific literature. However, broader information relating to infection fatality rates were never discussed in press releases, in news items or in the press. In all likelihood, personally considered risk of death from COVID-19 was likely to be disproportionate, compared to the risk of, for example, suicide, which takes the life of 600 New Zealanders annually, [157] or suffering a heart attack, which kills 10,000 New Zealanders annually. [158] Suicide and heart attacks in New Zealand are at epidemic levels, not COVID-19.

Throughout Summer 2022 in New Zealand, families must accept a medical intervention in the form of a novel mRNA genetic therapy in order to access a vaccine pass which permits them to engage in economic and social life. A vaccine pass providing evidence of a medical intervention -which cannot prevent transmission and infection.

The public's perception of a health threat is predictive of behaviour and strongly associated with compliance. The state and media have, in concert, promoted 'case' numbers, which includes a/symptomatic infection rates and false-positives, promoted negativity and fear.[159] [160] Fear was directly associated with compliance with policy measures from

[153] WorldoMeters. Accessed February 7, 2022. https://www.worldometers.info/coronavirus/country/new-zealand/
[154] Office of the Prime Minister, (2022, Jan 25). Post-Cabinet Press Conference. *Hansard Transcript.* https://www.beehive.govt.nz/sites/default/files/2022-01/Hansard%20Transcript%20-%20Press%20Conference%20-%20Tuesday%2025%20January%202022_0.pdf
[155] My Vaccine Pass. https://covid19.govt.nz/covid-19-vaccines/covid-19-vaccination-certificates/my-vaccine-pass/
[156] McKenzie, P. (2022, Jan 10). New Zealand not prepared for Omicron outbreak expected in 'matter of weeks', experts warn. *The Guardian.* https://www.theguardian.com/world/2022/jan/10/new-zealand-not-prepared-for-omicron-outbreak-expected-in-matter-of-weeks-experts-warn
[157] Office of the Chief Coroner (2021, Oct 4) *Suicide Statistics* Press release. https://coronialservices.justice.govt.nz/assets/Uploads/Chief-Coroner-releases-annual-suicide-statistics-launches-new-web-tool-with-Ministry-of-Health2.pdf
[158] Ministry of Health (2018). *Health and Independence Report 2017. The Director-General of Health's Annual Report on the State of Public Health.* Ministry of Health, Wellington. https://www.health.govt.nz/system/files/documents/publications/health-and-independence-report-2017-v2.pdf
[159] Bhattercharya J & Makridis CA (2020, Dec 3). Facts — not fear — will stop the pandemic. https://thehill.com/opinion/healthcare/528612-facts-not-fear-will-stop-the-pandemic
[160] Sacerdote B. et al (2020) Why Is All COVID-19 News Bad News? https://www.nber.org/papers/w28110

April 2020.[161] [162] Prime Minister Ardern was confident that Covid policies would create a two-tier society in October 2021.[163] This comment was made when it was evident that the Sars-Cov-2 virus would not severely harm the majority of the New Zealand population, and when harms from the mRNA genetic vaccines and the particular risk from the spike protein were accumulating in the scientific literature.

The scientific literature supports fear messaging in order to secure compliance for increasing restrictions. However the Ardern governments simple slogan 'case rate', 'protect family' and 'get boosted' narratives – overlayed with rights restrictions and an unprecedented barrage of quick-throughput law-making - hints at demagoguery, 'a natural tendency in representative democracies, a temptation to seduce them rather than convince them'.[164] While interpretations historically focussed on demagogues who manufactured outrage against an elite, activities central to demagogic activity involves marginalisation of minority communities, and the direction of anger towards the authority of the demagogue to fix or control the situation. Through this the demagogue engages in a 'concerted effort to create confusion in order to break down established norms of conduct, institutions, and the law.'[165] 'Demagogues thrive on simple slogans, where serious politics requires examination of detail.'[166] The repetitive rhetoric of 'case' receives the lion's share of Government, media and public attention, not the *risk*.

It's a very fine line between following the nudging science, and stepping into the territory of a demagogue.

6. ELIMINATION AT ALL COSTS

The Department of Premier and Cabinet's COVID-19 group's mission, was to 'to mobilise the collective capacity of government to eliminate COVID-19 while sustaining our economy and social cohesion.'[167]

Elimination 'focuses on zero-tolerance towards new cases, rather than a goal of no new cases'. [168] Elimination of case infection rate was locked into policy by a very small group of actors early in 2020.[169] The state agenda, ushering regulation towards tighter controls and mandatory vaccination was reinforced by academic papers supporting an elimination strategy, a system of aggressive suppression.[170] In New Zealand, this appears to have been initially suggested in March 2020 by Michael Baker and colleagues.[171] Elimination was theorised to work because of New Zealand's Island nation status. This was an interesting theory, as coronaviruses circulate and recirculate. Elimination advocates never appeared to be able to extrapolate the inevitabilities of border management 2, or 6 years out; nor the terrible legacy of island populations, two or three centuries ago, when foreign infectious disease, which had heretofore never been endemic, caused significant harm.

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[161] Harper CA. et al (2021). Functional Fear Predicts Public Health Compliance in the COVID-19 Pandemic. *International Journal of Mental Health and Addiction* 19, 1875–1888. https://doi.org/10.1007/s11469-020-00281-5

[162] Segal S. et al (2021). Policymakers as safe havens: The relationship between adult attachment style, COVID-19 fear, and regulation compliance. Personality and Individual Differences, 177, 110832. https://doi.org/10.1016/j.paid.2021.110832

[163] The Spectator (2021, Oct 21) Comment. Saint Jacinda Backs a Two-Tier Society. *The Spectator*. https://www.spectator.co.uk/article/saint-jacinda-backs-a-two-tier-society

[164] Liogier, R. (2017) France's Neither-Nor Election, April 12, 2017. *New York Times*

[165] Hoffman, S.G. (2018) The Responsibilities and Obligations of STS in a Moment of Post-Truth Demagoguery. *Engaging Science, Technology, and Society*, 4(2018), 444-452. https://doi.org/10.17351/ests2018.259 p.449

[166] Grayling, A.C. (2017). *Democracy and its Crisis.* Oneworld Publications. P.119

[167] DPMC (2021, April). COVID-19 Group. https://dpmc.govt.nz/our-business-units/covid-19-group

[168] Skegg Review (2021). Letter to Hon Ayesha Verrall. Strategic COVID-19 Public Health Advisory Group.

[169] MoH (2020, May 9). Case and contact management: monitoring and reporting to achieve and sustain elimination of COVID-19. https://www.health.govt.nz/system/files/documents/publications/covid-19-case-and-contact-management-monitoring-and-reporting-to-achieve-and-sustain-elimination-of-covid-19-9may2020.pdf

[170] Lu, G. et al. (2021). COVID-19 in Germany and China: mitigation versus elimination strategy. *Global Health Action*, 14, 1-11. https://doi.org/10.1080/16549716.2021.1875601

[171] Baker, M.G. et al. (2020, Apr 3) Editorial: NZMJ New Zealand's elimination strategy for the COVID-19 pandemic and what is required to make it work. *The New Zealand Medical Journal*, 133(1512), PMID: 32242173 https://journal.nzma.org.nz/journal-articles/new-zealands-elimination-strategy-for-the-covid-19-pandemic-and-what-is-required-to-make-it-work

A paper from June 2021, published 2022 demonstrated the obsession with elimination, it stated that the 'probability of elimination steadily increases with vaccine coverage.'[172] The authors of this paper were experts in mathematics and statistical modelling. But they have been profoundly incorrect at estimating the trajectory of this coronavirus, and they have systematically ignored public health maxims of infectious disease and they have swept not at risk individuals into modelling scenarios, ignoring risk from the vaccine, waning and herd immunity. In the discussion section of this paper they stated 'children will be crucial to minimising the potential for transmission and reaching the population immunity threshold.' This is the type of science used to require New Zealand's population to reach a vaccination status in the 90th percentile, regardless of individual risk.

The most influential policy document between June and August 2021 this time was the Skegg Review.[173] Even at this early stage of the vaccination roll out, before mandates, David Skegg acknowledged the rapid production of Sars-Cov-2 variants and the potential for these variants to be less responsive to the vaccines and for the potential for the variants to evolve to be less damaging. This paper did not consider age stratified risk. However even the uncertainties in this paper did not deviate the state from the looming mandates that would result in mass job losses due to the public's refusal to accept a novel mRNA genetic vaccine.

The potential for vulnerable populations to be protected, and for appropriate strategies and technologies to be implemented to ensure these communities were supported and protected, was never publicly encouraged.

More papers shepherding the elimination strategy were released by New Zealand authors. Baker and colleagues' opinion piece was published[174]; an editorial by David Skegg[175]; a Te Pūnaha Matatini article by Alex James and colleagues.[176] Professor Rod Jackson authored an opinion piece in the New Zealand Herald stating that for everyone 1 our of 100 people infected will die of Covid-19, stating that 'Learning to live with Covid 19 coronavirus is not a viable option.'[177] Offshore, The Lancet comment pieces by Oliu-Barton and colleagues[178] and Heywood and MacIntyre[179] were published. None of these papers discussed age stratified risk, nor natural (or herd) immunity. These papers did not draw attention to the principles of infectious disease management, enshrined in the 1956 Health Act, nor contemplated a disproportionate risk to children and young people from lockdown, isolation and vaccination. [180]

The well-established positive public health strategies for infectious disease prevention, that Skegg himself, just prior to the Covid19 pandemic, criticised as consistent failures of leadership that should have addressed the determinants of health, were conspicuous by their absence. Sub-standard housing, high levels of obesity, poor quality drinking-water and unsafe workplaces, are all complex factors that contribute to New Zealanders' poor health ranking, compared to other OECD countries.[181]

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[172] Steyn, N. et al. (2022) A COVID-19 vaccination model for Aotearoa New Zealand. *Scientific Reports,* 12, 2720. https://doi.org/10.1038/s41598-022-06707-5
[173] Skegg Review (2021). Letter to Hon Ayesha Verrall. Strategic COVID-19 Public Health Advisory Group.
[174] Baker, M.G. et al. (2020). New Zealand's COVID-19 elimination strategy. *Med J Aust.* 213(5), 198-200e1. https://doi.org/10.5694/mja2.50735
[175] Skegg D. (2021). Editorial: Defining covid-19 elimination. *BMJ,* 374, n1794. https://doi.org/10.1136/bmj.n1794
[176] James, A. et al. (2020, Dec 8). *Modelling support for the continued elimination strategy.* Report. Te Pūnaha Matatini December 8, 2020. https://cpb-ap-se2.wpmucdn.com/blogs.auckland.ac.nz/dist/d/75/files/2017/01/Elimination-Strategy-TPM-website.pdf
[177] Jackson, R. (2020, Aug, 18). Rod Jackson: Learning to live with Covid 19 coronavirus is not a viable optionhttps://www.nzherald.co.nz/business/rod-jackson-learning-to-live-with-covid-19-coronavirus-is-not-a-viable-option/RQYLGVNIWS7BGU33TRHBK6KPNQ/
[178] Oliu-Barton, M. et al (2021). Comment: SARS-CoV-2 elimination, not mitigation, creates best outcomes for health, the economy, and civil liberties. *The Lancet,* 2021 12-18 June; 397(10291): 2234–2236. https://doi.org/10.1016/S0140-6736(21)00978-8
[179] Heywood, A.E. & Macintyre C.R. (2020). Comment: Elimination of COVID-19: what would it look like and is it possible? *The Lancet* 20(9),1005-1007, https://doi.org/10.1016/S1473-3099(20)30633-2
[180] Kostoff, R.N. (2021). Why are we vaccinating children against COVID-19? *Toxicology Reports,* 8, 1665-1684. https://doi.org/10.1016/j.toxrep.2021.08.010
[181] Skegg, D. (2019) The Health of the People. Bridget Williams Books Ltd.

The Skegg Review[182] assumed that vaccines were safe and effective, however did not conduct a literature review, nor explore the rate of hospitalisation and death by infection rate.

The Skegg Review 'locked in' a predilection for mandates of frontline workers and erroneously claimed that 'People who report having recovered from COVID-19 should still be required to be vaccinated, because vaccination provides stronger immune protection than natural infection'. [183]

This was incorrect at time of writing, as there was no scientific evidence supporting this claim, and Skegg must have known this. Natural immunity was always going to produce a broader overarching biologically structural response, because of the design of the technology. The mRNA genetic vaccine did not function similarly to historically-recognised vaccines, the mRNA genetic vaccine relied on immunity derived from a single spike protein which would never have the same broad response as natural infection. There was always going to be a risk that the genetic vaccine would not produce long-lasting immunity, nor be able to meaningfully prevent transmission of infection.

In New Zealand, Dr Simon Thornley and the Plan B doctors were perhaps the most early vocal critics and the most roundly attacked. In a September 2021 Simon Thornley, Arthur Morris and Gerhard Sundborn expressed that they did not consider elimination a sound policy arguing that elimination would always be unlikely and impaired by immunosenescence in the elderly. [184] Thornley emphasised the different risk ratio between different age groups In a late 2021 article where Professor Rod Jackson misleadingly stated there was no 'trial evidence' that ivermectin works (there is plenty of evidence, and clinical trials are not conventionally appropriate for multidrug treatments) Radio New Zealand referred to Thornley as a 'discredited epidemiologist'.[185] The pharmaceutical industry friendly New Zealand Doctor magazine called Plan B 'dangerous misinformation.'[186]

As early as September 2021, natural immunity was confirmed to be more effective against further infection than vaccine acquired immunity,[187] and this evidence continued to accumulate until Omicron, demonstrate Skegg's claim was incorrect.[188] [189] [190]

The Skegg Review's absence of evidence paper, cited one paper which was also pro-elimination, The Lancet comment piece by Oliu-Barton et al..[191] One of these authors had professional conflicts of interest, as a member of GAVI, the Vaccine Alliance. It's startling that no analysis of the scientific literature occurred to provide evidence of the claim. The June Skegg paper was embargoed until August 2021, due to the fact, perhaps, that it was likely to be controversial.

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[182] Skegg Review (2021, Jun 20). Letter to Hon Ayesha Verrall. Strategic COVID-19 Public Health Advisory Group. Future of the Elimination Strategy. embargoed until August 2021 https://covid19.govt.nz/assets/reports/Independent-Advisory-Groups/Strategic-COVID-19-Public-Health-Advisory-Group-Advice-to-Minister-Verrall-June-2021.pdf

[183] Skegg Review (2021). Letter to Hon Ayesha Verrall. Strategic COVID-19 Public Health Advisory Group.

[184] Lee A., Thornley S., Morris AJ., Sundborn G. (2022) Should countries aim for elimination in the covid-19 pandemic? *BMJ*, Sept. 370, m3410. https://doi.org/10.1136/bmj.m3410

[185] Blake-Person, N. (2021, November, 16). National distances itself from ex-MP after video with discredited academic https://www.rnz.co.nz/national/programmes/checkpoint/audio/2018820774/national-distances-itself-from-ex-mp-after-video-with-discredited-academic

[186] Vause, J. (2021, May 27) There's fringe thinking, and then there's dangerous Plan B talk NZ Doctor https://www.nzdoctor.co.nz/article/opinion/theres-fringe-thinking-and-then-theres-dangerous-plan-b-talk

[187] Gazit et al. Comparing SARS-CoV-2 natural immunity to vaccine-induced immunity: reinfections versus breakthrough infections. preprint. https://doi.org/10.1101/2021.08.24.21262415

[188] Alejo, J.L. et al. (2022). Research Letter: Prevalence and Durability of SARS-CoV-2 Antibodies Among Unvaccinated US Adults by History of COVID-19. *JAMA* Published Online: February 3, 2022. https://doi.org/10.1001/jama.2022.1393

[189] Wang et al. (2021). Ultrapotent antibodies against diverse and highly transmissible SARS-CoV-2 variants. *Science* 373(6556), https://doi.org/10.1126/science.abh1766

[190] For links to published papers see: Alexander, P.E. (2021, Oct 17) (Epidemiologist, former WHO consultant) 150 Research Studies Affirm Naturally Acquired Immunity to Covid-19: Documented, Linked, and Quoted. Brownstone Institute. https://brownstone.org/articles/79-research-studies-affirm-naturally-acquired-immunity-to-covid-19-documented-linked-and-quoted/

[191] Oliu-Barton, M. et al. (2021). Comment: SARS-CoV-2 elimination, not mitigation, creates best outcomes for health.

The June 2021 Skegg Review was included in the Bills Digest of the COVID-19 Public Health Response Amendment Bill (No 2) which prompted the November regulatory cascade.[192]

The historic aim of public health is the promotion of health and the prevention of disease. This is different from medicine which focuses on the treatment and cure of individual patients. Health is more than simply the absence of a disease, it is holistic and open-ended – different groups are differently vulnerable to different factors, and this is why public health stretches across legal, political, cultural, practical and moral considerations. To achieve this, public health historically applied ethical principles, as values, to navigate the nuanced, interlocking and uncertain terrain of social, economic, medical and biological life.[193] Cultural competence also includes the co-creation of knowledge, that allows healthcare professionals insights into individuals' lived experiences.

To all appearances, New Zealand's approach to Covid-19 elimination campaign has distorted and eroded historically recognised public health maxims – which include moral considerations and recognise that human health, rights and individual autonomy are interlinked.[194] But there have been no authoritative ethics-based voices with the expertise and clout to challenge the medical narrative. How has New Zealand arrived here – when only a few – to all ends – recalcitrant academics and doctors appear to deviate from the public 'rinse and repeat, vaccinate, mask & vaccine pass' rhetoric?

7: VACCINE AS (TOXIC) VECTOR FOR AUTHORITARIAN POLICIES

In March 2021 the Ardern government signed a contract with Pfizer that secured the capability for the state to vaccinate the entire population. From this early stage, Prime Minister Ardern directly associated receipt of the genetic vaccine with freedom, stating 'With every person who gets vaccinated, New Zealand gets one step closer to moving away from restrictions to manage COVID-19. [195] Earlier supplies had arrive the month before, with the vaccine rollout commencing in February 2021 with border and MIQ workers the first citizens to be injected.[196] Vaccine mandates were predicated on a fundamental assumption - that vaccination would be the primary, i.e. *only* treatment, and hospitalisation and/or death were unlikely to be prevented unless the medical treatment was accepted by all New Zealanders. No early treatment was offered.

No virus has ever been controlled without authorities accounting for the role of herd immunity. A vaccine for a respiratory coronavirus was always going to involve uncertainty. The history of coronavirus vaccine development from the 1960's was peppered with failure, and antibody dependent enhancement and the specific risk of cardiomyopathy related to coronaviruses had been recognised in earlier coronavirus vaccine

[192] COVID-19 Public Health Response Amendment Bill (No 2). MP in Charge Chris Hipkins. https://www.parliament.nz/en/pb/bills-and-laws/bills-proposed-laws/document/BILL_115898/covid-19-public-health-response-amendment-bill-no-2
[193] Childress, J.F. et al. (2002). Public Health Ethics: Mapping the Terrain. *Journal of Law, Medicine & Ethics*, 30 (2002), 169–177. https://doi.org/10.1111/j.1748-720x.2002.tb00384.x.
[194] Childress, J.F. et al. (2002). Public Health Ethics: Mapping the Terrain. *J Law Med Ethics.* 30,3, 170-178 https://doi.org/10.1111/j.1748-720x.2002.tb00384.x
[195] Ardern J. & Hipkins C. (2021, Mar 8). Govt purchases enough Pfizer vaccines for whole country. https://www.beehive.govt.nz/release/govt-purchases-enough-pfizer-vaccines-whole-country
[196] Ardern J., & Hipkins, C. (2021, February, 15). First batch of COVID-19 vaccine arrives in NZ. https://www.beehive.govt.nz/release/first-batch-covid-19-vaccine-arrives-nz

research.[197] The 'vaccine' involved the deployment of novel uncertain technology, instead of standard 3-year trials, the FDA permitted Pfizer to terminate the BNT162B2 study after 6 months, and then offered the vaccine to the placebo recipients, muddying the trial.[198]

Efficacy for the BNT162B2 was derived by success in preventing occurrence of symptoms of the respiratory infection. Efficacy did not consider the overall prevention of hospitalisation and death, nor contrast the adverse event rate in order to establish the cost-benefit ratio of risk following injection. It's important to note that potential for prevention of transmission of infection was never studied in the mRNA genetic vaccine clinical trials. [199] Efficacy for Medsafe,[200] was determined by the results of the clinical trials, including the trials for the Pfizer BNT162b2 genetic vaccine, the major endpoint of which was an immune response generated by the vaccine in a 7 and 14 day window.

From an early stage the vaccines could not produce sterilizing immunity, nor prevent transmission of infection and circulating Sars-Cov-2 was likely to generate mutants.[201] The scientific implication of this early understanding should have been firstly, to immediately recognised that viral replication of circulating variants would be disinhibited by herd immunity. Vaccinated populations carried a double-edged risk, if they were likely to experience inflammation/autoimmune risks, this would make them more vulnerable to future Sars-Cov-2 variants. The second implication was that highly vaccinated populations where immune systems are impaired already, might produce the conditions where the virus could become increasingly harmful (pathogenic priming, or antibody dependent enhancement). As Danish researchers stated:

'Variants of concern have typically been the result of persistent infections in immunocompromised people that can cause the virus to mutate more frequently because the person's immune system cannot clear the virus as quickly as the immune system of a healthy person.'[202] [203]

In addition, the technology posed distinct risks with the insertion of a self-replicating spike protein into humans. There was tremendous prospect for spike-protein driven inflammation; early studies had previously acknowledged a coronavirus-myocarditis connection, and there was evidence that a foreign protein would spur autoimmune reactions in cells.[204] [205]

This knowledge was never discussed in New Zealand, nor was herd immunity debated. The New Zealand government urged families to get vaccinated to protect whanau, inferring this would prevent transfer of infection, prevention of transmission of infection was never an endpoint to secure approval for the novel mRNA genetic vaccine. However, from at least October 2021 there was substantial evidence that contradicted

[197] Kennedy, R.F. (2021) The Real Anthony Fauci.
[198] ClinicalTrials.gov Study to describe the Safety, Tolerability Immunogenicity and Efficacy of RNA Vaccine Candidates in Healthy Individuals. April 30, 2020. https://clinicaltrials.gov/ct2/show/NCT04368728
[199] Vaccines and Related Biological Products Advisory Committee Meeting December 10, 2020 FDA Briefing Document Pfizer-BioNTech COVID-19 Vaccine Sponsor: Pfizer and BioNTech. https://www.fda.gov/media/144245/download
[200] Medsafe. COVID-19 Vaccine Approval – Questions and Answers. Published: 27 November 2020 Revised 28 October 2021. Accessed February 11, 2022. https://www.medsafe.govt.nz/COVID-19/q-and-a-vaccine-approval.asp
[201] Kennedy, R.F. (2021) The Real Anthony Fauci. P.70
[202] Benn C. Rapid Response. Should we delay covid-19 vaccination in children https://www.bmj.com/content/374/bmj.n1687/rr-8
[203] Peacock et al. SARS-CoV-2 one year on: evidence for ongoing viral adaptation. J Gen Virol. 2021;102(4).
[204] Polykretis, P. (2022). Role of the antigen presentation process in the immunization mechanism of the genetic vaccines against COVID-19 and the need for biodistribution evaluations. *Scandinavian Journal of Immunology https://doi.org/10.1111/sji.13160*
[205] Vanden Bossche, G. (2022, Mar). Poor virus-neutralizing capacity in highly C-19 vaccinated populations could soon lead to a fulminant spread of Sars-CoV-2 super variants that are highly infectious and highly virulent in vaccinees while being fully resistant to all existing and future spike-based C- 19 vaccines https://uploads-ssl.webflow.com/616004c52e87ed08692f5692/6244c3b09ad5701f3ec17765_GVB_s%2Banalysis%2Bof%2BC-19%2Bevolutionary%2Bdynamics.pdf

this claim, indicating that the mRNA injection did not meaningfully prevent transmission.[206] [207] As of April 1, 2022, texts are still being sent out urging all who are 5 and up to get vaccinated.

There is no established signal – no red line – established by either Medsafe or the other adverse event database management institutions, when consent for the provisional (and emergency) approvals would be withdrawn due to an excess of hospitalisation and death following injection.

Historically, in the USA, five unexplained deaths would result in a black-box warning, while 50 deaths would result in withdrawing a drug. Safety signals need not accrue before investigation, as the FDA has acknowledged, 'it only takes a single well-documented adverse event to justify a safety signal investigation'.[208]

The capture of all people under mandates, includes pregnant women. Historically, medicines for pregnant women, particularly to novel technologies, have been regarded cautiously. Pfizer/Biontech acknowledged that use in pregnancy and lactation and vaccine effectiveness are areas identified as missing information. [209] Requiring pregnant women to be vaccinated in order to be employed was a significant shift from earlier cautious approaches. However, the Immunisation Handbook, in advising pregnant women were not medically exempt from vaccination, stated: '[p]regnancy is associated with higher risk from COVID-19 compared to the general population and therefore this group are a priority for vaccination.'[210] The Handbook cited a study which did not consider risk stratified by health (multimorbidity) status.[211]

From April 2021 published literature confirmed risk in pregnancy aligned with multimorbidity and socio-economic status.[212] Despite this information being available, all pregnant women were captured under global mandate regulations.

CHILDREN AND YOUNG PEOPLE

An increasing body of evidence suggests that children and young people are now more at risk of vaccination than Covid-19, particularly if they have had a previous Sars-Cov-2 infection. The Unite Against COVID-19 Campaign and the traffic light system directly coerced healthy young people and children to accept the novel genetic vaccine. Young people who are not at risk of Covid-19, were required to accept the 'jab' in order to work until April 2022, and children over 12 were required to be vaccinated in order to engage in activities. Although not compulsory, high schools were asking parents to identify whether their teenager was vaccinated.

There have been no nuanced discussions to help the public, state employees, elected members or the judiciary negotiate the uncertainty. The result of the traffic light nudge campaign was to ensure that places of community gathering and human connection have been *interdit* - forbidden. While the large commercial retail outlets and liquor stores remained exempt – the taken-for-granted places of community: libraries and swimming pools, cafés, universities, campsites in national parks, even Parliament, required a vaccine pass to

[206] Nordström, P. et al. Effectiveness of Covid-19 Vaccination Against Risk of Symptomatic Infection, Hospitalization, and Death Up to 9 Months: A Swedish Total-Population Cohort Study. *The Lancet*, https://doi.org/10.1016/S0140-6736(22)00089-7
[207] Singanayagam et al. Community transmission and viral load kinetics of the SARS-CoV-2 delta (B.1.617.2) variant in vaccinated and unvaccinated individuals in the UK: a prospective, longitudinal, cohort study. The Lancet (2021). Doi 10.1016/S1473-3099(21)00648-4
[208] Gortler D. (2022, February 10). Former Senior FDA Official: Manufacturers, FDA Negligent In Not Investigating Covid-19 Vaccine Risks To Heart Health. The Federalist. https://thefederalist.com/2022/02/10/former-senior-fda-official-manufacturers-fda-negligent-in-not-investigating-covid-19-vaccine-risks-to-heart-health/
[209] Pfizer and BioNTech (2020, Dec 10). Vaccines and Related Biological Products Advisory Committee Meeting.
[210] Ministry of Health and New Zealand Government (2022, Jan). *Immunisation Handbook*, released September 2020, updated January 2022. https://www.health.govt.nz/system/files/documents/publications/immunisation-handbook-2020-sep20-v15a.pdf p.184
[211] Mullins E, Hudak ML, Banerjee J, et al. (2021) Pregnancy and neonatal outcomes of COVID-19: co-reporting of common outcomes from PAN-COVID and AAP SONPM registries. *Ultrasound in Obstetrics and Gynecology*, 57(4), 573-581
[212] Brandt J.S. et al. (2021) Epidemiology of corona virus disease 2019 in pregnancy: risk factors and associations with adverse maternal and neonatal outcomes. *American Journal of Obstetrics & Gynecology*, 224, 389e1-9. https://doi.org/10.1016/j.ajog.2020.09.043

enter. For young people, for whom connection and social contact is essential, there was no question they should take the mRNA vaccine if they were to socialise with friends.

Throughout the mandate and vaccine pass phases, the potential for the injection to prevent transmission of infection (as with some childhood vaccines) was simply not studied in New Zealand.

Early modelling demonstrated that young people and children were not at significant risk of hospitalisation or death.[213] [214] Children are at low risk of hospitalisation and death and primarily healthy children aged 5-11 in Delta had an extremely low risk of ICU admission, at .2/10,000.[215]

From early on, it was recognised that children and young people who were at risk, were more likely to have associated medical morbidities.[216] A recent study demonstrated that all adolescents that died had medical morbidities.[217] U.S. data suggests that 33% of children may fit in this category, and that 70% of children hospitalised for Covid-19 have one or more medical morbidities.[218] For those at risk, any benefit from vaccination now that Omicron is in New Zealand, may be short lived.[219] There are options other than mRNA vaccination to manage Sars-Cov-2 infection, and preventative treatment specifically targeted to high-risk children and young people was published in August, 2021.[220]

Young men are at particularly high risk. Krug et al (2022) [221] applied 2 different analytical processes to assess risk in adolescents. The first risk-benefit analysis considered gender, health status and looked at risk by Delta and Omicron variants.:

> 'For adolescent boys without medical comorbidities, their risk of post- vaccination dose two myo/pericarditis exceeded their risk of COVID- 19 hospitalization during delta after one dose of vaccination. During omicron, the additional benefit of the second dose cannot be estimated due to the reduced VEH [Vaccine effectiveness against hospitalization] with dose two compared to dose one. Our risk- benefit analysis also does not favour the second dose, or even one dose, in all boys 12– 17 with a history of infection. However, clinicians are cautioned to consider the specific risks associated with the child's health circumstances in their guidance. In girls with or without medical comorbidities, our risk- benefit analysis does not favour two doses if they have a history of SARS- CoV- 2 infection. By some estimates, even a first dose after previous infection is not favourable for girls 12– 17 without comorbidities.'

The second analysis considered the 120-day hospitalisation rate:

> According to our VAERS estimates, the myo/pericarditis risk for a 12– 15- year- old boy without a comorbidity receiving his second dose of the vaccine is 2.8x higher than his 120- day risk of

[213] Ferguson N.M. et al. (2020). Report 9: Impact of non-pharmaceutical interventions (NPIs) to reduce COVID-19 mortality and healthcare demand. March 16, 2020. Imperial College COVID-19 Response Team. https://www.imperial.ac.uk/media/imperial-college/medicine/sph/ide/gida-fellowships/Imperial-College-COVID19-NPI-modelling-16-03-2020.pdf
[214] Smith, C. et al. (2021). Deaths in Children and Young People in England following SARS-CoV-2 infection during the first pandemic year: a national study using linked mandatory child death reporting data. *Nature Medicine,* 28, 185-192. https://doi.org/10.1038/s41591-021-01578-1
[215] Sorg A.L. et al. (2021) Risk of Hospitalization, severe disease, and mortality due to COVID- 19 and PIMS- TS in children with SARS- CoV- 2 infection in Germany. medRxiv [preprint]. 2021;. doi:10.1101/2021.11.30.21267048. Accessed on December 8.
[216] Havers F.P. et al (2021). Hospitalization of Adolescents Aged 12–17 Years with Laboratory-Confirmed COVID-19 — COVID-NET, 14 States, March 1, 2020–April 24, 202. *MMWR*, 70,23, 851-857. US Department of Health and Human Services Centers for Disease Control and Prevention
[217] Funk, A.L. et al. (2022) Outcomes of SARS-CoV-2–Positive Youths Tested in Emergency Departments, *JAMA Network Open*, 5(1):e2142322. https://doi.org/10.1001/jamanetworkopen.2021.42322. Supplemental Online Content, eTable 1.
[218] Krug, A. et al. (2022). BNT162b2 Vaccine- Associated Myo/Pericarditis in Adolescents: A Stratified Risk- Benefit Analysis. Eur J Clin Invest. 00, e13759. https://doi.org/10.1111/eci.13759
[219] Dorabawila, V. et al. (2022). Effectiveness of the BNT162b2 vaccine among children 5-11 and 12-17 years in New York after the Emergence of the Omicron Variant. medRxiv. https://doi.org/10.1101/2022.02.25.22271454 Posted February 28,2022.
[220] Alexander P.E. et al. (2021). Early ambulatory outpatient sequenced antiviral multidrug COVID-19 treatment (including for Delta or similar variants) for high-risk children and adolescents. https://scholarworks.utrgv.edu/mss_fac/195/
[221] Krug, A. et al. (2022). BNT162b2 Vaccine- Associated Myo/Pericarditis in Adolescents Discussion

> hospitalization even without adjusting for 40% 31- 34 incidental hospitalizations. For older boys, the risk of myo/pericarditis is 1.6x their cumulative 120- day hospitalizations. For those with medical comorbidities, the 120- day COVID hospitalization rates are higher than their rates of myo/pericarditis during times of moderate to high incidence if not adjusting for a possible 40% overestimate of hospitalization rates.) During times of very high incidence, such as the omicron wave, the 120- day risk of COVID- 19 hospitalization for boys with a medical comorbidity is 1.7x- 3x higher than their risk of vaccine- associated myo/pericarditis and is approximately equivalent to their post- vaccination myo/pericarditis risk after adjustment for incidental admissions.'[222]

The cognitive dissonance required to obediently acquiesce – for both the rulers and the ruled, is monumental. There was no 'out' for children and young people to gain an exemption from mandated vaccination, the stories of the Minister of Health and Ashley Bloomfield denying exemptions for vulnerable people who considered that the genetic vaccine posed a health risk are extensive and alarming.[223] Historically, public health must navigate the conflicts that emerge between privacy and justice, and between different conceptions of justice. This has never been evident in New Zealand's Unite campaign.

8: PRACTICAL & ETHICAL QUESTIONS: VACCINATION AS THE PRIMARY, MANDATED TREATMENT

There were very early signals that the mRNA genetic vaccines were neither safe, nor effective. When did scientists start to signal that the mRNA vaccines were sufficiently risky that automatic global vaccination of not-at-risk individuals should cease?

Toxicologist Dr Janci Lindsay was one of the first to signal risk in an April 2021 presentation to the U.S. CDC. Lindsay drew attention to the potential for the spike protein to promote blood clot development.[224] In May 2021, 50 doctors and scientists co-signed a paper urging mass vaccination to be paused. They expressed concern that there was evidence that the spike protein caused endothelial damage, and that there was potential for vaccination to drive autoimmunity and antibody dependent enhancement. They noted evidence that large numbers of adverse events were occurring. They questioned the basis of a 'rationale for administering the vaccine to every individual when the risk of dying from COVID-19 is not equal across age groups and clinical conditions and when the phase 3 trials excluded the ly, children and frequent specific conditions?'[225]

In June 2021 in the U.K., after the first 5 months of data were released following vaccination of nearly 39 million people, Dr Tess Lawrie drew attention to the signal coming from the U.K. Yellow Card system where 1,253 deaths and 888,196 ADRs (256,224 individual reports) were reported. At this early stage in the U.K. five broad, clinically relevant categories could be identified.

A. Bleeding, Clotting and Ischaemic ADRs
B. Immune System ADRs
C. 'Pain' ADRs
D. Neurological ADRs
E. ADRs involving loss of Sight, Hearing, Speech or Smell
F. Pregnancy ADRs[226]

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[222] Krug et al. (2022). BNT162b2 Vaccine- Associated Myo/Pericarditis in Adolescents
[223] Voices for Freedom and Lynda Wharton of the Health Forum worked tirelessly to support concerned publics in efforts to secure exemptions, most attempts were denied by the state.
[224] Margulis, J. (2021, May 19). Halt Covid Vaccine, Prominent Scientist Tells CDC. https://assets-global.website-files.com/606d3dece4ec3c3866cc798a/60a5fff10d77970857d15281_32%20Margulis%202021%20Halt%20Covid%20Vaccine%2C%20Prominent%20Scientist%20Tells%20CDC.pdf
[225] Bruno, R. et al. (2021, May 24). SARS-CoV-2 mass vaccination: Urgent questions on vaccine safety that demand answers from international health agencies, regulatory authorities, governments and vaccine developers
[226] Lawrie, T. (2021, June 9). RE: Urgent preliminary report of Yellow Card data up to 26 th May 2021. https://ukfreedomproject.org/wp-content/downloads/Urgent%20Preliminary%20Report%20of%20Yellow%20Card%20Data%209-6-2021.pdf

Yet Pfizer and the FDA were already aware of the substantial risk profile (far beyond risk for influenza vaccines[227]) in April 2021.[228] An enormous range of adverse event data was held by the FDA at this stage, with adverse events including death, Bell's palsy, Guillain-Barré syndrome, non-haemorrhagic and haemorrhagic stroke, acute myocardial infarction, deep vein thrombosis, pulmonary embolism, anaphylaxis, myocarditis or pericarditis, narcolepsy, appendicitis, immune thrombocytopenia, disseminated intravascular coagulation, encephalomyelitis, and transverse myelitis.

A. PROVISIONAL APPROVAL – NO REQUIREMENT FOR YEARS OF SAFETY DATA

Problematically, (for a pandemic involving a coronavirus), the quick-throughput clinical trials enabled the drug to be approved as a medical treatment, after only two months of safety data. The Emergency Use Authorization (EUA) request was submitted to the FDA November 20, 2020. After a second dose was administered, participants were observed up to November 14, 2020 around 2 months after the second dose.[229] [230] The trials did not require the drug to prevent transmission of infection (an historic requirement of vaccines). Vaccines traditionally required 10-15 years of time-dependent testing protocols to ensure safety and efficacy[231] and were withdrawn even when a relatively low death rate was signalled. Yet Governments including the USA and in New Zealand have not withdrawn emergency use authorisation or provisional approval after significant rates of harm have been repeatedly declared. [232] [233] [234] [235] [236] Other methods were put in place during the trials, which appeared to obfuscate knowledge. Data recording hospitalisation and death following vaccination frequently ignore the time period immediately after the vaccination, when hospitalisation or death might be temporally associated with the medical intervention. [237] For example, patients who die within 2 weeks of vaccination are counted as unvaccinated, as they have yet to form antibodies, yet the 2-week window post vaccination was the most likely time when vaccine injury would occur.

Yet the mRNA genetic vaccines are vastly different from traditional live attenuated virus or inactivated vaccines. BNT162bt contained the genetic information which encoded for the production of the viral spike protein. Lipid nanoparticles, composed of four lipids ALC-0315 (aminolipid) and ALC-0159 (PEG-lipid), DSPC and cholesterol, cloak to the BNT162b2 acting as the delivery vehicle. The proprietary ALC-0315 and ALC-0159 lipids are referred to as novel 'excipients'. The main declared ingredient, the variable ionizable lipid ALC-0315, binds to the mRNA molecule. The LNPs metabolise only slowly, and they are not readily

[227] Montano, D. Frequency and Associations of Adverse Reactions of COVID-19 Vaccines Reported to Pharmacovigilance Systems in the European Union and the United States. *Frontiers in Public Health*, 9, 756633. https://doi.org/10.3389/fpubh.2021.756633
[228] Pfizer Worldwide Safety. BNT162b2 5.3.6 Cumulative Analysis of Post-authorization Adverse Event Reports. FDA-CBER-2021-5683-0000054. https://phmpt.org/wp-content/uploads/2021/11/5.3.6-postmarketing-experience.pdf
[229] Pfizer and BioNTech (2020, Dec 10). Vaccines and Related Biological Products Advisory Committee Meeting. FDA Briefing Document Pfizer-BioNTech COVID-19 Vaccine Sponsor: Pfizer and BioNTech. https://www.fda.gov/media/144245/download
[230] BioNTech (2021). Application: Pfizer and BioNTech Initiate Rolling Submission of Supplemental Biologics License Application to U.S. FDA for Booster Dose of COMIRNATY® in Individuals 16 and Older. August 25, 2021. https://investors.biontech.de/static-files/6932835c-50c8-4b79-96dc-725cc6b7d0bb?fbclid=IwAR2bMkL4vi2ZtDwmyIVk6WDI2i7_CsPFk7A4Yavr8rTf8J8Dn0clN3ANsNs
[231] Rose J. (2021). Critical Appraisal of VAERS Pharmacovigilance: Is the U.S. Vaccine Adverse Events Reporting System (VAERS) a Functioning Pharmacovigilance System? *Sci, Pub Health Pol, & Law*. 3, 100-129 https://cf5e727d-d02d-4d71-89ff-9fe2d3ad957f.filesusr.com/ugd/adf864_0490c898f7514df4b6fbc5935da07322.pdf
[232] Johnson, R. (2022) Letter to the Secretary of the Department of Defense. February 1, 2022. https://www.ronjohnson.senate.gov/services/files/FB6DDD42-4755-4FDC-BEE9-50E402911E02
[233] Johnson, R. (2021) Expert Panel on Medical Mandates and Vaccine Injuries. Senator Ron Johnson. Vaccine Mandates Expert Panel Highlights. November 10, 2021. https://www.youtube.com/watch?v=lkVN3KwDfv
[234] Rose, J. (2022) I don't know what to say.... Discussion of Efficacy of the mRNA-1273 SARS-CoV-2 Vaccine at Completion of Blinded Phase. Feb 2, 2022. https://jessicar.substack.com/p/i-dont-know-what-to-say?utm_source=url
[235] Voices for Freedom, (2021). Courageous Convos: Lynda Wharton. July 17, 2021. https://odysee.com/@voicesforfreedom:6/lynda-wharton:d
[236] Wharton, L. (2022) Lynda Wharton of the Health Forum | FreeNZ. January 17, 2022. https://odysee.com/@FreeNZ:d/lynda-wharton:5
[237] Dagan, N. et al. (2021). Brief Communication: Effectiveness of the BNT162b2 mRNA COVID-19 vaccine in pregnancy. *Nature Medicine*, 27, 1693-1695, https://doi.org/10.1038/s41591-021-01490-8

eliminated in urine.[238] [239] In January 2021 an Australian Government report demonstrated that the liquid nanoparticles following a single dose became widely distributed into organs, and at highest levels in lungs, ovaries and spleen.[240]

Scientists have suggested that the lipid nanoparticle could play a part in the pathogenesis (development) of damage, either harming cells or producing an immune reaction.[241] The spike protein in the Sars-Cov-2 natural infection lacks the LNP-assisted capability to enter human tissue on the same scale as the formulated technology. These nanoparticles appear to facilitate entry of the mRNA into organs including the heart and may facilitate entry to the cell nucleus.

Rather than 'being' natural mRNA, the mRNA was modified with N1-methyl-pseudouridine. There is potential that the persistence of mRNA at least 60 days after injection[242] may be connected to the activity of the pseudouridine which acts to promote stability, or persistence of the mRNA in the body.[243]

The Pfizer Safety Data Sheet (SDS)[244] for BNT162b2 demonstrates the absence of safety data for the individual ingredients, including the lipid nanoparticles. The ingredients have not been tested against European regulations (often the most stringent). The SDS advises that contact hazards for the lipid nanoparticle are unknown, and that the percentage composition of the ingredients are withheld as a trade secret. The product has not been assessed for endocrine disrupting properties.

While much of the processes of authorisation remain unclear, Pfizer approached the New Zealand Environmental Protection Authority (NZEPA) on the 29th of January 2021 (APP204176) seeking confirmation (a Section 26 Determination)[245] that Comirnaty COVID-19 Vaccine (BNT162b2 [mRNA]) did 'not meet the definition of an organism (nor of a genetically modified organism) and therefore cannot be considered a new organism under section 26 of the Hazardous Substances and New Organisms (HSNO) Act 1996. Three days later a staff assessment report was produced by the NZEPA recommending that BNT162b2 does not meet the definition of an organism in the Act, and therefore it cannot be a new organism for the purpose of the Act.[246] On February 11 the NZEPA decision-making committee, Kerry Laing and Julie Everett-Hincks, determined that BNT162b2 was not a new organism.[247]

[238] Pfizer Worldwide Safety. BNT162b2 5.3.6 Cumulative Analysis of Post-authorization Adverse Event Reports. FDA-CBER-2021-5683-0000054. https://phmpt.org/wp-content/uploads/2021/11/5.3.6-postmarketing-experience.pdf
[239] New Zealand Data Sheet. https://www.medsafe.govt.nz/profs/Datasheet/c/comirnatyinj.pdf
[240] Australian Government (2021, Jan). Nonclinical Evaluation Report BNT162b2 [mRNA] COVID-19 vaccine (COMIRNATY™). Submission No: PM-2020-05461-1-2 Sponsor: Pfizer Australia P.45 https://www.tga.gov.au/sites/default/files/foi-2389-06.pdf
[241] Tsilingiris D. et al. (2022) Potential implications of lipid nanoparticles in the pathogenesis of myocarditis associated with the use of mRNA vaccines against SARS-CoV-2. *Metabolism Open*, 13, 100159. https://doi.org/10.1016/j.metop.2021.100159
[242] Röltgen, K. et al. (2022). Immune imprinting, breadth of variant recognition and germinal center response in human SARS-CoV-2 infection and vaccination *Cell*, 596, 109-113. https://doi.org/10.1016/j.cell.2022.01.018
[243] Borchardt, E.K. et al (2021). Regulation and Function of RNA Pseudouridylation in Human Cells. *Annu Rev Genet.* 54, 309-336. https://doi.org/10.1146/annurev-genet-112618-043830
[244] Pfizer Safety Data Sheet (2021, Dec 7). PF00092.
[245] Pfizer New Zealand Ltd. (2021, January 31). Kristen J. Perry. Application for Section 26 Determination. APP204176. https://www.epa.govt.nz/assets/FileAPI/hsno-ar/APP204176/APP204176-Application.pdf
[246] NZEPA (2021, Feb 3). Staff Assessment Report. APP204176. https://www.epa.govt.nz/assets/FileAPI/hsno-ar/APP204176/APP204176-Staff-Assessment-Report.pdf
[247] NZEPA (2021, Feb 11). Decision APP204176. https://www.epa.govt.nz/assets/FileAPI/hsno-ar/APP204176/APP204176-Decision.pdf

One of the most controversial claims concern a potential inclusion of graphene hydroxide as nanoparticles (perhaps an adjuvant).[248] [249] Speculation potentially rests on the capacity for graphene to act as a nano-scale superconductor.[250] [251] [252]

In April 2022 these vaccines continue to have provisional approval to November 3, 2023[253] using Section 23 of the Medicines Act.[254] The Ministry of Health has claimed an urgent clinical need[255] which infers there is no substitute treatment. Provisional consent is similar to emergency approval when a medical intervention has not completed all trials. Ministry of Health have stated

> 'COVID-19 vaccines have been given provisional approval in New Zealand because data to support the longer-term safety and efficacy of COVID-19 vaccines is not yet available.'[256]

However, the Medicines Act, Section 23(1) notes that provisional consent would be granted when the Minister was 'of the opinion that it is desirable that the medicine be sold, supplied, or used on a restricted basis for the treatment of a limited number of patients.' Broadscale vaccination of over 90% of the population is more than a limited number of patients, and it is unclear whether this inconsistency has been resolved through administrative processes.

B. ETHICAL AND RISK-BASED IMPLICATIONS OF A GENETIC VACCINE

Regulators conventionally require that medical drugs undergo standard trials to evaluate whether a drug has genotoxic or carcinogenic causing potential. Conventional vaccines require two years of safety data.

It would have been difficult to secure a market approval for novel mRNA gene transfer technologies, or genetic vaccines[257] in the past.[258] Genetic vaccines conventionally require five years of safety studies, and the potential for the treatment to be mutagenic, carcinogenic and teratogenic are required. This has not been done for the mRNA genetic vaccines which present unique risks.

The mRNA genetic vaccine fundamentally differed from legacy vaccines. Pfizer used the claim that the mRNA technology was a vaccine to evade testing to identify if the technology contained cancer causing potential. Genotoxicity studies were claimed to be not required because the 'the components of the vaccine

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[248] Xu L. et al (2016). Functionalized graphene oxide serves as a novel vaccine nano-adjuvant for robust stimulation of cellular immunity. *Nanoscale*, 6, 8, 3785-95. https://doi.org/10.1039/c5nr09208f.
[249] Madrid, P.M. (2021). Interim Report Graphene Oxide Detection in Aqueous Suspension. https://www.docdroid.net/Ov1M99x/official-interim-report-in-english-university-of-almeria-pdf
[250] New Zealand Lawyers Speaking Out with Science. (2022, Mar 22). Open letter to the police Commissioner and request for a meeting. https://nzdsos.com/2022/03/17/nzlsos-open-letter-to-police-commissioner/
[251] Demming A. (2018 Feb 28). Superconductivity – pairing up with nanotechnology. https://physicsworld.com/a/superconductivity-pairing-up-with-nanotechnology/
[252] Bailey, S. (2022, March 2022) NZ Scientist Examines Pfizer Jab Under The Microscope https://odysee.com/@drsambailey:c/nz-scientist-examines-pfizer-jab-under-the-microscope:6
[253] Medsafe (2022, Mar 20). Approval status of COVID-19 vaccines applications received by Medsafe https://www.medsafe.govt.nz/COVID-19/status-of-applications.asp
[254] Medicines Act 1981 https://www.legislation.govt.nz/act/public/1981/0118/latest/whole.html#DLM53790
[255] Ministry of Health. COVID-19: Assessing and approving the vaccines. What provisional approval means. Accessed 22-02-22 https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-vaccines/covid-19-assessing-and-approving-vaccines#:~:text=months%20to%20respond.-,The%20approval%20process%20for%20Pfizer,that%20it%20meets%20international%20standards
[256] Ministry of Health. COVID-19: Assessing and approving the vaccines. Page last updated: 04 February 2022 Accessed February 11, 2022. https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-vaccines/covid-19-assessing-and-approving-vaccines#:~:text=months%20to%20respond.-,The%20approval%20process%20for%20Pfizer,that%20it%20meets%20international%20standards.
[257] Nakagami, H. (2021). Development of COVID-19 vaccines utilizing gene therapy technology. *International Immunology*, 33:10;521-527. https://doi.org/10.1093/intimm/dxab013
[258] Kostoff, R.N. (2021). Why are we vaccinating children against COVID-19? *Toxicology Reports*, 8, 1665-1684. https://doi.org/10.1016/j.toxrep.2021.08.010

construct are lipids and RNA and are not expected to have genotoxic potential'. [259] Carcinogenicity studies were not conducted as:

> 'the components of the vaccine construct are lipids and RNA and are not expected to have carcinogenic or tumorigenic potential. Carcinogenicity testing is generally not considered necessary to support the development and licensure of vaccine products for infectious diseases.'

In addition, there were no standalone trials to observe whether the technology contained immunotoxic potential.[260] However, potential mechanisms that might promote cancer include the potential for the technology to inhibit double-stranded DNA repair and promote reverse transcription into the human genome.[261] [262] [263] [264]

Recently a study revealed that the germinal centres in lymph nodes continue to express the spike protein until at least 2 months after injection, when the research period ended.[265] As Robert Malone suggests 'Protein expression is not being turned off, because the immune response against the mRNA/pseudoridine complex is either not happening or is ineffective… In either case, this is regulatory nightmare.'[266]

C. MANDATES FOR A MEDICAL INTERVENTION BASED ON A 2-YEAR-OLD VIRUS

All currently, provisionally-approved vaccines [267] are based on the original wildtype virus, rather than designed to promote a protective immune response to the newer variants. If they are based on the original wild-type 2020 virus, they are akin to using a 2-year-old influenza vaccine during flu season.

D. MANDATES WHILE OTHER EARLY TREATMENTS ARE DENIED

This mainstream assumption that novel vaccines are the only medical treatment, has been incorrect since early on in the pandemic.[268] There is increasing evidence that hospitalisation and death occurs in vaccinated populations, and that there are early treatments that firstly, prevent viral replication in the first stage of infection, and that secondly, reduce risk of hospitalisation and death by preventing and lessening cascading health loss that can present after the first few days. The public are largely ignorant of these treatments, which can be taken at home in the early stages of infection and prevent hospitalisation and death.[269] [270] [271] [272]

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[259] Pfizer. BNT162b2 Module 2.4. Nonclinical Overview. FDA-CBER-2021-5683-0013861. P.29 https://phmpt.org/wp-content/uploads/2022/03/125742_S1_M2_24_nonclinical-overview.pdf
[260] Pfizer. BNT162b2 Module 2.4. Nonclinical Overview. FDA-CBER-2021-5683-0013861. P.29 https://phmpt.org/wp-content/uploads/2022/03/125742_S1_M2_24_nonclinical-overview.pdf
[261] Jiang H, Mei YF. SARS-CoV-2 Spike Impairs DNA Damage Repair and Inhibits V(D)J Recombination In Vitro. Viruses. 2021 Oct 13;13(10):2056. doi: 10.3390/v13102056. PMID: 34696485; PMCID: PMC8538446.
[262] Zhang Let al. (2020). SARS-CoV-2 RNA reverse-transcribed and integrated into the human genome. bioRxiv [Preprint]. 2020 Dec 13:2020.12.12.422516. doi: 10.1101/2020.12.12.422516. PMID: 33330870; PMCID: PMC7743078.
[263] Aldén, M., et al (2022) Intracellular Reverse Transcription of Pfizer BioNTech COVID-19 mRNA Vaccine BNT162b2 In Vitro in Human Liver Cell Line. Curr. Issues Mol. Biol. 2022, 44, 1115-1126. https://doi.org/10.3390/cimb44030073.
[264] Rose, J. (2022, Mar 20). Substack: Genotoxicity and Carcinogenicity studies were NOT done because... the WHO. https://jessicar.substack.com/p/genotoxicity-and-carcinogenicity?s=r
[265] Röltgen, K. et al. (2022). Immune imprinting, breadth of variant recognition and germinal center response in human SARS-CoV-2 infection and vaccination *Cell*, 596, 109-113. https://doi.org/10.1016/j.cell.2022.01.018
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[267] Ministry of Health (2022, Feb 2). COVID-19: Purchasing the vaccines/ https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-vaccines/covid-19-assessing-and-approving-vaccines/covid-19-purchasing-vaccines
[268] McCullough P.A. et al. (2020) Multifaceted highly targeted sequential multidrug treatment.
[269] Association of American Physicians and Surgeons, (2022, Jan). Physician List & Guide to Home-Based COVID Treatment. https://aapsonline.org/covidpatientguide/
[270] Canadian Covid Care Alliance. Early Treatment Protocols (n.d.). https://www.canadiancovidcarealliance.org/treatment-protocols/
[271] World Council for Health, (2021, Sept). Early Covid-19 treatment guidelines: A practical approach to home-based care for healthy families. https://worldcouncilforhealth.org/resources/early-covid-19-treatment-guidelines-a-practical-approach-to-home-based-care-for-healthy-families/
[272] Front Line COVID-19 Critical Care Alliance (n.d.). Prevention & Treatment Protocols for COVID-19. https://covid19criticalcare.com/covid-19-protocols/

It is medically and ethically questionable that governments did meaningfully assess the potential for early treatments to prevent hospitalisation and death with the arrival of Omicron. When Omicron was detected it was evident that the heavy mutation on the spike protein on the Omicron variant produced increased infectivity and antibody invasion.[273] Internationally, early treatments have assisted health practitioners to navigate around the issues of vaccine waning, and failure as novel variants evade the vaccine and to lower the risks of hospitalisation and death in vulnerable communities.

Early treatments can act as a safe substitute for individuals at elevated risk of vaccine-harm, or at high risk of hospitalisation and death because of age and health status. Early treatment can assist those at risk of vaccine failure, such as immunocompromised/immunosuppressed individuals[274] and people with the overlapping diseases of obesity and diabetes from hospitalisation and death.[275]

Repurposed drugs with a long history of safe use have been integrated into the early treatment framework, and much like protocols for other illnesses, such as HIV/AIDs, these treatments exert a combinatory effect. Government agencies have stated randomised control trials were necessary to prove safety and efficacy of alternative treatments, but RCTs have limited applicability, particularly when multitarget treatments are deployed to deal with multiple complex pathologies and have likely synergistic effects, and the drugs have a long history of safe use.

Preventative treatments can be deployed as emergency medicine for conventionally not at-risk from COVID-19, including healthy people under 65, pregnant mothers, children and young people, enabling families to avoid the risks of the genetic vaccines, and particularly avoid ongoing booster regimes of unproven benefit. Most pregnant women who have been hospitalised have been obese and from lower income groups, which might have drawn attention to the social determinants and drivers of risk in infectious disease pandemics.[276]

COVID-19 early and hospital-based treatments have been heavily restricted.[277] Early treatments were identified in 2020 as an important modality for the treatment of Covid-19 and the prevention of hospitalisation and death. [278] [279] In September 2021, the only approved treatment for COVID-19 was dexamethasone.[280] Ivermectin is an exceptionally safe and cheap antiviral drug that has been used off-label for decades, including for various infectious diseases. [281] Ivermectin's inventor won a Nobel prize. In New Zealand there has been no balanced discussion of the antiviral medication, particularly to acknowledge its safety record, which contributed to the inventor of the drug being awarded a Novel prize. There have been no New Zealand-based meta-analyses conducted of the peer reviewed literature.[282] Instead, from April 2020, the Ministry of Health specifically warned against ivermectin, inferring the drug was risky by stating 'When ingested in high doses, Ivermectin can have a serious effect on humans, with symptoms including low blood pressure, worsening

[273] Araf, Y. et al (2022). Omicron variant of SARS-CoV-2: Genomics, transmissibility, and responses to current COVID-19 vaccines. *Hournal of Medical Virology,* 94,5 1825-1832. https://doi.org/10.1002/jmv.27588
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https://www.health.govt.nz/system/files/documents/pages/csu_09_july_2021_covid-19_pharmaceutical_treatments.pdf
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[279] Heidary F. and Gharebaghi R. (2020). Ivermectin: a systematic review from antiviral effects to COVID-19 complementary regimen. *The Journal of Antibiotics,* 73, 593-602. https://doi.org/10.1038/s41429-020-0336-z
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https://www.health.govt.nz/system/files/documents/information-release/h202110964_response.pdf
[281] Database of all ivermectin COVID-19 studies. 148 studies, 98 peer reviewed, 78 with results comparing treatment and control groups. February 15, 2022 https://c19ivermectin.com/
[282] Ministry of Health (2021, Oct 14). Response to request for official information.
https://www.health.govt.nz/system/files/documents/information-release/h202112498_response.pdf

asthma, severe autoimmune disorders, seizures and liver damage.'[283] The decision to not permit Ivermectin appears based on a two external reviews and the findings of US and European regulators.[284] [285] In 2020 Radio New Zealand discredited the antiviral by referring to it as a head lice treatment,[286] [287] with warnings against ivermectin continuing through 2021.[288] In New Zealand, Medsafe and other institutions suppressed access to repurposed drugs with a long history of safe use and that governments are requiring much more rigorous safety data for older drugs with a long history of safe use.[289] The antiviral ivermectin has been confiscated at the New Zealand border and is now held by Medsafe.[290]

As they are predominantly off-patent, they impose marginal cost on the tax-payer from the genetic vaccines or newer, more expensive drugs such as Molnuprivar or Remdesivir

E. SIGNALS DISMISSED AND DOWNPLAYED: ACCUMULATING VACCINE RISK PROFILE

> 'More than 1000 peer- reviewed studies evidence a multitude of adverse events in COVID- 19 vaccine recipients. Such studies report severe adverse reactions following vaccination, including thrombosis, thrombocytopenia, myocarditis, pericarditis, cardiac arrhythmias, nervous system disorders and other alterations.'[291]

The Pfizer BNT162b2 genetic vaccine appears to be neither safe nor effective. From an early stage the BNT162B2 product resulted in a high death and adverse risk rate that would normally prevent a product from being released on to the global market. The public were not aware that the endpoints for 'efficacy' did not include prevention of hospitalisation and death. The supplemental data revealed that it was apparent that at the 6-month stage Pfizer's trials did not reduce overall death.[292] [293]

By the 30th of April 2021 the US Federal Drug Administration and Pfizer was aware that instead, high death, and high adverse incident rates were associated with the BNT162B2. In the Cumulative Analysis of Post-Authorization Adverse Event Reports to February 28, 2021, 3% of the 42,000 adverse events reported were a fatal event. The total number of injections that resulted in the 42k of events remain redacted.[294]

In the 6 months following the first dose of the Pfizer BNT162b2 genetic vaccine, during the blinded, controlled period, 15 BNT162b2 and 14 placebo recipients died. The Supplementary Appendix of the Thomas

[283] Ministry of Health (2020, Apr 8). Caution about Laboratory COVID-19 Report. https://www.health.govt.nz/news-media/news-items/caution-about-laboratory-covid-19-report
[284] Medsafe (2021, Sept 6). Risks of importing or prescribing ivermectin for prevention or treatment of COVID-19. https://www.medsafe.govt.nz/safety/Alerts/ivermectin-covid19.htm
[285] Ministry of Health Science Update (2021, Jul 9).
[286] RNZ (2020, Aug 25). Why scientists are looking at existing medications to treat Covid-19 https://www.rnz.co.nz/news/world/424400/why-scientists-are-looking-at-existing-medications-to-treat-covid-19
[287] RNZ Mediawatch (2020, Sept 6). Unproven Covid 'cure' gets big dose of coverage. https://www.rnz.co.nz/national/programmes/mediawatch/audio/2018762446/unproven-covid-cure-gets-big-dose-of-coverage
[288] RNZ (2021, Sept 15). Bloomfield warns against social media Covid-19 misinformation. https://www.rnz.co.nz/news/national/451542/bloomfield-warns-against-social-media-covid-19-misinformation
[289] Kory P. (2022, Feb 2). Substack. The Alphabet Health Agencies Ignoring of the Repurposed Drug Fluvoxamine. https://pierrekory.substack.com/p/the-alphabet-health-agencies-ignoring?r=iutjw&utm_campaign=post&utm_medium=web&s=r
[290] Medsafe Request for official information. H202112779. https://www.health.govt.nz/system/files/documents/information-release/h202113089_response.pdf
[291] Polykretis, P. (2022). Role of the antigen presentation process in the immunization mechanism of the genetic vaccines against COVID-19 and the need for biodistribution evaluations. *Scandinavian Journal of Immunology https://doi.org/10.1111/sji.13160*
[292] Thomas, S.J. et al. (2021). Six Month Safety and Efficacy of the BNT162b2 mRNA COVID-19 Vaccine. *NEJM*. 385, 1761-1773 https://doi.org/10.1056/NEJMoa2110345 Adverse Events Page 6.
[293] Thomas et al 2021 Six Month Safety and Efficacy of the BNT162b2 mRNA COVID-19 Vaccine. Supplementary Appendix Table S4 https://www.nejm.org/doi/suppl/10.1056/NEJMoa2110345/suppl_file/nejmoa2110345_appendix.pdf
[294] Pfizer Worldwide Safety. BNT162b2 5.3.6 Cumulative Analysis of Post-authorization Adverse Event Reports. FDA-CBER-2021-5683-0000054. https://phmpt.org/wp-content/uploads/2021/11/5.3.6-postmarketing-experience.pdf

paper at 6 months is also quite clear – in the placebo group, one person had a cardiac arrest, while in the BNT162b2 four participants died from cardiac arrest. [295] [296]

Another study looking at the Moderna mRNA-1273 showed that not only was the death rate higher from the drug (which was theoretically meant to prevent death in a pandemic); the adverse incidents and the severity of these incidences were 3 times more common and twice as severe in those that received the injection.[297]

There is a likelihood that vaccination increased risk for non-communicable and communicable disease in not at risk of Sars-Cov-2 populations. The briefing documents to the U.S. Food and Drug Administration (FDA) demonstrated that both the FDA and Pfizer/ BioNTech were aware of the potential for myocarditis and vaccine-associated enhanced disease (VAED). The clinical trials did not demonstrate a protective effect for people with compromised immune systems. The document noted that for immunocompromised groups, there was not a sufficient patient cohort to identify efficacy outcomes.[298] The FDA and Pfizer/ BioNTech were aware of the potential for vaccine-associated enhanced respiratory disease (VAERD) and decreased effectiveness as immunity waned over time. VAERD is an important potential risk. [299]

In January 28th, 2022, New Zealand's risk management plan for all of the provisionally approved genetic vaccines, Comirnaty[300]; AstraZeneca[301]; and Janssen[302] were updated. The documents demonstrate that physicians are aware of harms include anaphylaxis, myocarditis, pericarditis, thrombosis and thrombocytopenia and Guillain-Barré syndrome. On the following day the Unite Against Covid-19 website was updated to include these harms.[303] It is unclear whether these harms were published on the Medsafe site *before* the January 2022 update. However, at least until February 17, risks relating to the booster remained significantly downplayed in the public-facing Ministry of Health COVID-19 branded documents.[304]

The updating of risk management plans and the MoH website information demonstrates that information concerning these harms have been accessible to doctors and the public since late January 2022. There did not appear to be a media release to advise the public of the revised recognition of the risk profile of the vaccines.[305]

However, it can be assumed New Zealand authorities were always aware of these risks, perhaps they were always detailed in New Zealand risk management plans, just never broadly communicated to the public. Pfizer had submitted a Risk Management Plan to the European Medicines Agency in 2020, that included the content detailed in the Medsafe January 2022 documents.[306] It can be assumed that New Zealand authorities also had access to this data.

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[295] Thomas, S.J. et al. (2021). Six Month Safety and Efficacy of the BNT162b2 mRNA COVID-19 Vaccine. *NEJM*. 385, 1761-1773 https://doi.org/10.1056/NEJMoa2110345 Adverse Events Page 6.
[296] Thomas et al 2021 Six Month Safety and Efficacy of the BNT162b2 mRNA COVID-19 Vaccine. Supplementary Appendix Table S4 https://www.nejm.org/doi/suppl/10.1056/NEJMoa2110345/suppl_file/nejmoa2110345_appendix.pdf
[297] Supplement to: El Sahly HM, Baden LR, Essink B, et al. Efficacy of the mRNA-1273 SARS-CoV-2 vaccine at completion of blinded phase. N Engl J Med 2021;385:1774-85. DOI: 10.1056/NEJMoa2113017. https://www.nejm.org/doi/suppl/10.1056/NEJMoa2113017/suppl_file/nejmoa2113017_appendix.pdf
[298] Pfizer and BioNTech (2020, Dec 10). Vaccines and Related Biological Products Advisory Committee Meeting.
[299] Pfizer and BioNTech (2020, Dec 10). Vaccines & Related Biological Products Advisory Committee Meeting. P. 44
[300] Medsafe (2022, Feb 27). Updated summary of risk management plan for Comirnaty (COVID-19 mRNA vaccine). Children/Adults. https://www.medsafe.govt.nz/COVID-19/Comirnaty-RMP.pdf
[301] Medsafe (2022, Feb 27). Summary of the risk management plan for COVID-19 Vaccine AstraZeneca (ChAdOx1-S/AZD1222). January 27, 2022. Accessed 22/02/22. https://www.medsafe.govt.nz/COVID-19/AstraZeneca-RMP.pdf
[302] Medsafe (2022, Feb 27). Summary of the risk management plan (version 1.2) for COVID19 Vaccine Janssen (Ad26.COV2.S). January 27, 2022. Accessed 22/02/22. https://www.medsafe.govt.nz/COVID-19/Janssen-RMP.pdf
[303] Unite Against COVID-19. Side effects of COVID-19 vaccines (2022). Last updated: 28 January 2022 at 4:16 pm. Accessed 22/02/2022 https://covid19.govt.nz/covid-19-vaccines/how-to-get-a-covid-19-vaccination/what-to-expect-when-you-get-your-vaccinations/side-effects-of-covid-19-vaccines/
[304] See Note 2.
[305] Unite against COVID-19. Latest News 27-30 January 2021. https://covid19.govt.nz/news-and-data/latest-news?start=50
[306] European Medicines Agency (2021, Feb 19). Assessment report. Comirnaty Common name: COVID-19 mRNA vaccine (nucleoside-modified). Procedure No. EMEA/H/C/005735/0000. EMA/707383/2020 Corr.1*1 https://www.ema.europa.eu/en/documents/assessment-report/comirnaty-epar-public-assessment-report_en.pdf

MEDSAFE: RISK MANAGEMENT PLAN UPDATE FOR COVID-19 VACCINES - JANUARY 27, 2022			
VACCINE TYPE	**IMPORTANT RISKS**	**POTENTIAL RISKS**	**MISSING INFORMATION**
COMIRNITY COVID-19 mRNA vaccine	Anaphylaxis. Myocarditis and pericarditis.	Vaccine-associated enhanced disease (VAED) including vaccine associated enhanced respiratory disease (VAERD).	Use in pregnancy and while breast feeding. Use in immunocompromised patients. Use in frail patients with co-morbidities (eg, chronic obstructive pulmonary disease (COPD), diabetes, chronic neurological disease, cardiovascular disorders) Use in patients with autoimmune or inflammatory disorders. Interaction with other vaccines. Long term safety data.
ASTRAZENECA (ChAdOx1-S/AZD1222)	Thrombosis with thrombocytopenia syndrome. Thrombocytopenia, including immune thrombocytopenia. Guillain-Barré syndrome. Anaphylaxis.	Thrombosis. Nervous system disorders, including immune-mediated neurological conditions. Vaccine-associated enhanced disease (VAED), including vaccine associated enhanced respiratory disease (VAERD).	Use during pregnancy and while breastfeeding. Use in immunocompromised patients Use in frail patients with co-morbidities (eg, chronic obstructive pulmonary disease, diabetes, chronic neurological disease, cardiovascular disorders). Use in patients with autoimmune or inflammatory disorders. Interactions with other vaccines. Long-term safety.
JANSSEN (Ad26.COV2.S)	Anaphylaxis.	Vaccine-associated enhanced disease (VAED), including vaccine associated enhanced respiratory disease (VAERD). Venous thromboembolism.	Use in pregnancy and while breastfeeding. Use in immunocompromised patients. Use in patients with autoimmune or inflammatory disorders. Use in frail patients with comorbidities (eg, chronic obstructive pulmonary disease (COPD), diabetes, chronic neurological disease, cardiovascular disorders). Interaction with other vaccines. Long-term safety.

The risk management plan for Comirnaty expressed concern that injection from the medical intervention produced an important potential risk for Vaccine-associated enhanced disease (VAED) including vaccine-associated enhanced respiratory disease (VAERD). It stated that there was evidence of risk:

> *VAED is considered a potential risk because it has not been seen in human studies with this or other COVID-19 vaccines being studied. It has not been seen in vaccine studies in animal models of the SARS-CoV-2 virus either. However, in selected vaccine studies in animal models as well as in some laboratory studies in animal cells infected with 2 other related coronaviruses (SARS-CoV-1 and MERSCoV), abnormalities in immune responses or cellular responses indicative of VAED were observed. Because of this, VAED is considered a potential risk. In the past there have been other examples of particularly respiratory viruses where VAED has been observed. For example, some*
>
> *children who received an inactivated respiratory syncytial virus vaccine (a different type of virus), had worse signs of disease when they were subsequently infected with respiratory syncytial virus.*
>
> *VAED is thought to occur by several mechanisms where the immune response is not fully protective and actually either causes the body to have an inflammatory reaction due to the type of immune*
>
> *response with specific types of T-cells, or the body does not produce enough strong antibodies to prevent SARS-CoV-2 infection of cells or produces weak antibodies that actually bind to the virus and help it to enter cells more easily, leading to worse signs of disease.*[307]

The risk of vaccine failure or waning in immunocompromised and immunosuppressed groups had been raised with Members of Parliament on the Health Committee in October 2021, and the important protective benefits of offering broader multitarget, or early treatments was emphasised.[308]

The problem of VAED adds to the potential risk faced by these groups, in accepting repeat injections from the genetic vaccine. This is stated by Medsafe:

> *It is thought that the potential risk of VAED may be increased in individuals producing a weak antibody response or in individuals with decreasing immunity over time.*[309]

The early Pfizer applications included risk for VAED. The potential for VAED to be a risk was noted in a January 2020 meeting but had been dismissed in New Zealand as the 'low prevalence of COVID-19 infection in New Zealand means that vaccine-associated enhanced disease (VAED) may be less of a risk compared with other countries.'[310]

Outside of New Zealand, VAED has been a recognised risk for some time. In an April 2021 document[311] the U.S. Food and Drug Administration conclusion of risks of the BNT162b2 Pfizer genetic vaccine that:

> *VAED may present as severe or unusual clinical manifestations of COVID-19. Overall, there were 37 subjects with suspected COVID-19 and 101 subjects with confirmed COVID-19 following one or both doses of the vaccine; 75 of the 101 cases were severe, resulting in hospitalisation, disability, life-threatening consequences or death.*

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[307] Medsafe. Updated summary of risk management plan for Comirnaty (COVID-19 mRNA vaccine). P.3
[308] PSGR (2021, Oct 21). Submission to the COVID-19 Public Health Response Amendment Bill (No 2). Physicians and Scientists for Global Responsibility. https://www.parliament.nz/resource/en-NZ/53SCHE_EVI_115898_HE16756/f803d4311783129cf51351e2593b36a272f11026
[309] Medsafe. Updated summary of risk management plan for Comirnaty (COVID-19 mRNA vaccine). P.4.
[310] Medsafe (2021, May 3) Minutes of the out of session medicines adverse reactions Committee Meeting 20 January 2020. https://www.medsafe.govt.nz/profs/adverse/MinutesOoS-20-jan-2021.htm
[311] U.S. Food & Drug Administration (2021, Apr 30). BNT162b2. 5.3.6 Cumulative Analysis of Post-authorization Adverse Event Reports. FDA-CBER-2021-5683-0000054. https://drtrozzi.org/wp-content/uploads/2022/01/Pfizer-Cumulative-Analysis-of-Post-authorization-Adverse-Event-Reports.pdf

Persistent uncertainties concerning the health effect of the genetic vaccine, brings to mind Donald Rumsfeld's February 2002 quote, on the uncertainties concerning weapons of mass destruction. Rumsfield stated:

> 'we also know there are known unknowns — that is to say, we know there are some things we do not know. But there are also unknown unknowns, the ones we don't know we don't know.'

Papers continue to be published that draw attention to both long- and short-term risk arising following exposure to the vaccine technologies. For example, the genetic vaccines may potentially induce an autoimmune response.[312] [313] Global vaccination may create the perfect environment for vaccine driven virulence evolution - antigenic escape where 'variants of target antigens evolve because they enable pathogens that are otherwise less fit to evade vaccine-induced immunity. The evolution of escape variants has been frequently observed.'.[314] [315] Immune function may be altered.[316] An increasing body of literature outlines that spike protein may play a primary role in post vaccination events.[317] [318] [319] [320] A study recently revealed that following vaccination, the spike protein persists in the lymph nodes for 8 weeks.[321] The spike protein can persist for 9 months following infection,[322] but how the spike protein persists in the body following repeat injections, in an uncontrolled environment remains unclear.

It is no secret that passive reporting systems are more likely to under-report risk.[323] [324] Public data continues to suggest that the mRNA genetic vaccines present more risk than government agencies depict.[325] [326] [327] [328] [329] Incidents of vaccine harm have been under-represented in New Zealand. There are alarming signals in New

[312] Turner, J.S. et al. (2021). SARS-CoV-2 mRNA vaccines induce persistent human germinal centre responses. Nature, 596, 109-113. https://doi.org/10.1038/s41586-021-03738-2
[313] Polykretis, P. (2022). Role of the antigen presentation process in the immunization mechanism of the genetic vaccines against COVID-19 and the need for biodistribution evaluations. Scandinavian Journal of Immunology https://doi.org/10.1111/sji.13160
[314] Read et al. (2015). Imperfect Vaccination Can Enhance the Transmission of Highly Virulent Pathogens. *PLoS Biol* 13(7): e1002198. https://doi.org/10.1371/journal.pbio.1002198
[315] Vanden Bossche, G. (2022, Mar). Poor virus-neutralizing capacity in highly C-19 vaccinated populations could soon lead to a fulminant spread of Sars-CoV-2 super variants that are highly infectious and highly virulent in vaccinees while being fully resistant to all existing and future spike-based C- 19 vaccines
[316] Föhse, F.K. et al. The BNT162b2 mRNA vaccine against SARS-CoV-2 reprograms both adaptive and innate immune responses. medRxiv Preprint. Doi 10.1101/2021.05.03.21256520
[317] Polykretis, P. (2022). Role of the antigen presentation process in the immunization mechanism of the genetic vaccines against COVID-19 and the need for biodistribution evaluations. Scandinavian Journal of Immunology https://doi.org/10.1111/sji.13160
[318] Jiang H. & Mei Y. SARS–CoV–2 Spike Impairs DNA Damage Repair and Inhibits V(D)J Recombination In Vitro. Viruses 2021, 13, 2056. https://doi.org/10.3390/v13102056
[319] Idrees D. & Kumar V. SARS-CoV-2 spike protein interactions with amyloidogenic proteins: Potential clues to neurodegeneration. Biochemical and Biophysical Research Communications. (2021) 554:94-98
[320] Ryu et al. Sars-Cov-2 spike protein induces abnormal inflammatory blood clots neutralized by fibrin immunotherapy. bioRxiv preprint. (2021) doi: 10.1101/2021.10.12.464152
[321] Röltgen et al. (2022). Immune imprinting, breadth of variant recognition, and germinal center response.
[322] Patterson et al. (2021). Persistence of SARS CoV-2 S1 Protein in CD16+ Monocytes 1 in Post-Acute Sequelae of COVID-19 (PASC) Up to 15 Months 2 Post-Infection. *Front. Immunol*. 12, https://doi.org/10.3389/fimmu.2021.746021
[323] Lazarus R, Klompas M. Electronic Support for Public Health–Vaccine Adverse Event Reporting System (ESP:VAERS) [Internet]. Available from: https://digital.ahrq.gov/sites/default/files/docs/publication/r18hs017045-lazarus-final-report-2 011.pdf
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[325] Raine, J. et al. (2022, Jan 19). Open Letter to the MHRA Regarding Child Death Data. HART Group. https://www.hartgroup.org/open-letter-to-the-mhra-regarding-child-death-data/
[326] Bardosh M. et al. (2022). The Unintended Consequences of COVID-19 Vaccine Policy.
[327] Johnson R. (2022, Feb 3). Sen. Johnson letter to Secretary Austin U.S. Department of Defense. Has DOD Seen an Increase in Medical Diagnoses Among Military Personnel? https://www.ronjohnson.senate.gov/services/files/FB6DDD42-4755-4FDC-BEE9-50E402911E02
[328] Johnson, R. (2021) Expert Panel on Medical Mandates and Vaccine Injuries. Senator Ron Johnson. Vaccine Mandates Expert Panel Highlights. November 10, 2021. https://www.youtube.com/watch?v=lkVN3KwDfv
[329] Rose, J. (2022) I don't know what to say.... Discussion of Efficacy of the mRNA-1273 SARS-CoV-2 Vaccine at Completion of Blinded Phase. Feb 2, 2022. https://jessicar.substack.com/p/i-dont-know-what-to-say?utm_source=url

Zealand [330] [331] [332] [333] that the Unite Against COVID-19 strategy of global vaccination has produced unjustified health harms. It is widely recognised that barriers to reporting exist[334] and that 'passive or spontaneous report systems suffer from serious under-estimation of adverse reactions.'[335]A recent release of government data in the UK prompted an open letter to the Joint Committee on Vaccination and Immunisation (JCVI), requesting that vaccines pause for children due to the increase in all-cause mortality for males aged 15-19.[336]

With global governments reluctant to respond to the warning signals noted by their own agencies, and with evidence that agencies are under-reporting harm, insurance companies' underwriters do have such leverage. They will only cover calculable risk that represents a viable business model. Recently, German insurance agency BKK ProVita wrote to the Paul Ehrlich Institute, an agency of the German Federal Ministry of Health to raise attention to their inhouse data which suggested that there had been an under-reporting of vaccine side-effects by public agencies. BKK ProVita regarded this '*als ehrebliches alarmsignal an'* - as a serious alarm signal.[337] In a presentation to the Indiana Chamber of Commerce, the chief executive officer of OneAmerica Life Insurance, Scott Davison, reported on excess death rates that the U.S. insurance industry were observing.[338]

New Zealand cases have relied on evidence supplied by the Crown that insist the genetic vaccine is safe and effective. It remains unclear what data has been supplied by the Crown in judicial review to justify claims that deaths were reduced in November 2021. Indeed, the advice to Cabinet in October 2020, contained no data on infection fatality rate.[339]

There are many different adverse events that have been reported following vaccination.[340] [341] [342] Harms such as allergic reaction and anaphylaxis; nerve damage (such as Guillain-Barré syndrome and Bell's Palsy); and blood clotting and pericarditis/myocarditis may not only be difficult to directly associated with a treatment, as the biological action that caused the harm may be unknown. Similar, adverse events may occur separately, or may co-occur.

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[333] Wharton L. (2022, Jan 17). Discussion of Citizens Database. https://odysee.com/@FreeNZ:d/lynda-wharton:5
[334] Lazarus et al. (2011). Electronic Support for Public Health–Vaccine Adverse Event Reporting System (ESP:VAERS). https://digital.ahrq.gov/sites/default/files/docs/publication/r18hs017045-lazarus-final-report-2011.pdf
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[336] Jones, R. et al. (2022, Feb 13). Open Letter from the Children's Covid Vaccines Advisory Group (CCVAG) to the JCVI:Pause vaccines for children pending urgent review. HART Group. https://www.hartgroup.org/open-letter-to-the-jcvi-pause-vaccines-for-children-pending-urgent-review/
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[338] Davison, S. (2021, Dec 31). Chamber of Commerce, Indiana Hospital Association discuss COVID impact. Scott Davison presentation at 21.25. CBS4 Indy. https://www.youtube.com/watch?v=5AOHrZHG5L0
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[340] Li, X. et al. (2021). Characterising the background incidence rates of adverse events of special interest for covid-19 vaccines in eight countries: multinational network cohort study. *BMJ* 373, n1435 https://doi.org/10.1136/bmj.n1435
[341] Open Vaers https://openvaers.com/covid-data
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IS THE CARDIOVASCULAR/CIRCULATORY SYSTEM AT GREATEST RISK?

Our cardiovascular system may be particularly vulnerable. Cardiovascular disease (CVD) is the biggest driver of death from non-communicable disease in the world.[343] CVD is a leading cause of mortality in New Zealand and is 'almost always' a consequence of atherosclerosis.[344]

Cardiac arrest occurs when the heart stops pumping. Factors which can contribute to cardiac arrest include cardiovascular disease which can be associated with clotting, cardiac arrhythmias[345], myocarditis and pericarditis [346] [347] as well as artherosclerosis.

A search for BNT162b2 and thrombotic thrombocytopenia and/or cerebral venous sinus thrombosis reveals an increasing body of literature, temporally linking these events to receipt of a dose of the mRNA genetic vaccine.[348] [349] [350] [351] [352]

Blood clotting/coagulation can be driven by external factors such as infection or medical treatment. Clotting is associated with vaccination[353] and funeral embalmers report extensive and novel clots in deceased clients.[354] Historically, cardiac arrest and myocardial infarction are the most common cause of death in people with thrombotic thrombocytopenic purpura (TTP).[355]

It's evident that injection with the genetic vaccine is associated with a risk for pericarditis/myocarditis, and that this is greater than the background rate observed prior to the rollout of the genetic vaccines.[356] [357] There are more cases occurring from the BNT162b2 than from the Moderna genetic vaccine and myocarditis risk increases with the second dose.[358]

Historically, heart problems in children and young people (CYP) are uncommon but are substantially more at risk of myocarditis after submitting to the mRNA gene therapy. Hospitalisation following vaccine-initiated myocarditis or pericarditis is common, and the rate of hospitalisation has been estimated at 87%.[359] Risk also

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[343] Joseph et al. (2017). Reducing the Global Burden of Cardiovascular Disease, Part 1: The Epidemiology and Risk Factors. *Circulation Research*, 121, 677–694 https://doi.org/10.1161/CIRCRESAHA.117.308903
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[352] Yahyavi-Firouz-Abadi, N. & Naik R.P. (2021). Cerebral venous sinus thrombosis associated with vaccine-induced thrombotic thrombocytopenia. *The Neuroradiology Journal.* 0(0) https://doi.org/10.1177%2F19714009211036687
[353] Ryu, J.K. et al. (2021) Sars-Cov-2 spike protein induces abnormal inflammatory blood clots neutralized by fibrin immunotherapy. *bioRxiv preprint.* (2021) https://doi.org/10.1101/2021.10.12.464152
[354] Kirsch S. (2022, Feb 7) Embalmer Richard Hirschman reveals novel clotting in 65% of cases. https://rumble.com/vucdbi-embalmer-richard-hirschman-reveals-novel-clotting-in-65-of-cases.html
[355] Wiernek, S.L. et al. (2018). Cardiac implications of thrombotic thrombocytopenic purpura. *World J Cardiol.* 10(12), 254-266. https://doi.org/10.4330/wjc.v10.i12.254.
[356] Rose J. McCullough P. (2021) WITHDRAWN: A Report on Myocarditis Adverse Events in the U.S. Vaccine Adverse Events Cardiac implications of thrombotic thrombocytopenic purpura. (2021) *Curr Probl Cardiol* (2021) Sep 30, 101011. https://doi.org/10.1016/j.cpcardiol.2021.101011 Paper withdrawn without explanation. Copy here.
[357] Chua, G.T. et al, (2021). Epidemiology of Acute Myocarditis/Pericarditis in Hong Kong Adolescents Following Comirnaty Vaccination. *Clinical Infectious Diseases*, ciab989, https://doi.org/10.1093/cid/ciab989
[358] Olster, M.E. et al. (2022). Myocarditis Cases Reported After mRNA-Based COVID-19 Vaccination in the US From December 2020 to August 2021. *JAMA*. 327(4), 331-340. https://doi.org/10.1001/jama.2021.24110
[359] Krug, A et al. (2022). BNT162b2 Vaccine- Associated Myo/Pericarditis in Adolescents

differs by gender. For example, males are more at risk from myocarditis, [360] whilst females are more at risk from cerebral venous sinus thrombosis.[361] Symptoms and markers of mRNA vaccine-derived myocarditis can persist for months afterwards.[362]

Risk of myocarditis from Sars-Cov-2 infection is vastly different. Older people are proportionately more at risk from myocarditis if they experience COVID-19 than CYP who are not at risk of myocarditis if they experience COVID-19.

Is the average citizen, the average elected member, aware of these relevant issues? The above issues raise worrying questions about democracy, freedom and the right to a choice over whether or not to accept a medical intervention, particularly from a novel technology where the *data to support the longer-term safety and efficacy of COVID-19 vaccines is not yet available.*

9: THE SOCIAL CONSTRUCTION OF KNOWLEDGE & IGNORANCE

Knowledge – as information - and ignorance, shapes what we now know and can act upon. The absence of discussion of infection fatality rates stratified by age, and the promotion of case numbers, demonstrates how information was weaponised to nudge the public in a particular direction, and accept a medical intervention from a treatment that had only 2 months of clinical trial data, instead of 10 to 15 years of data.

We often believe ignorance is the result of *not* doing something. Those who are ignorant are this way due to a choice, or absence of knowledge. Yet of course, ignorance and knowledge are tied to capabilities and access to resources. This is no different for science. The production of science is highly social, and the authority to determine what science is included in debate is strategically important and a direct function of the power of stakeholders.[363] [364] [365]

Sociological studies of ignorance recognise that knowledge is socially constructed and that ignorance can arise as strategically produced *non-knowledge*.[366] [367] Knowledge and ignorance is associated with historic access to resources and closely tied to institutional power. How risk is communicated and understood produces specific cultures that have ways of knowing and understanding – in public life and in scientific, academic and political communities.

As has been discussed, institutionalised drivers in science policy (which is closely associated with tertiary education institutions) favour innovation-based medicalised cultures. Institutional research directed to the production of medical technologies and medicine, produces institutional and cultural blind spots, as ignorance makes it difficult to produce health protective

Insisting on vaccine mandates without drawing attention to scientific and biological nuances – infection fatality rate, age-stratified risk, the risk of adverse events, and the knowledge there is little asymptomatic transmission of infection – not only draws attention to ethical and moral dilemmas – but whether fundamental tenets of public and administrative law are known or even understood by public servants.

[360] Olster, M.E. et al. (2022). Myocarditis Cases Reported After mRNA-Based COVID-19 Vaccination in the US
[361] Finsterer J & Zarrouk S. 2021 Post-SARS-CoV-2 vaccination venous sinus thrombosis
[362] Schauer J. et al (2022). Persistent Cardiac MRI Findings in a Cohort of Adolescents with post COVID-19 mRNA vaccine myopericarditis. *Journal of Pediatrics*, https://doi.org/10.1016/j.jpeds.2022.03.032
[363] Croissant, J. (2014). Agnotology: Ignorance and Absence or Towards a Sociology of Things that Aren't There. *Social Epistemology*, 28(1), 4-25. https://doi.org/10.1080/02691728.2013.862880
[364] Hess, D. (2015). Undone science and social movements. A review and typology. In M. Gross, & L. McGoey (Eds.), *Routledge International Handbook of Ignorance Studies* (pp. 141-154). Routledge.
[365] Frickel, S., & Moore, K. (Eds.). (2006). *The New Political Sociology of Science.* The University of Wisconsin Press.
[366] Gross M. & McGoey L. (2015). *Routledge International Handbook of Ignorance Studies.* ISBN: 978-1-315-86776-2
[367] McGoey, L. (2012). The logic of strategic ignorance. *The British Journal of Sociology*, 63(2), 553-576. https://doi.org/10.1111/j.1468-4446.2012.01424.x

policy and there is no institutional 'space' for robust research and science. Therefore in New Zealand in 2022, we have disease-based medical policy, and a disease-based medical system. It is apparent that the Ministry of Health is now predominantly a Ministry of Medicine. Medicine and medical technologies should form a subset of national health policy, rather than drive it.

It should have been expected, that very few authoritative experts were available to challenge the governments genetic vaccine narrative – the state has simply not created a safe space for researchers and scientists to challenge the power of medicalised narratives.

Medical training focuses on medicine. Western doctors have been educated in such a way that prioritises symptom detection and disease-based medical treatment. Much of their work involves drug management for patients with multiple conditions. It is normally assumed that neither metabolic conditions, nor mental illness, can be reversed. The culture of medicine is instead management of disease, and medicine has become more prescriptive. Yet how can health be protected if disease states, such as obesity, produce illness cascades, increasing vulnerability for depression, cancer, heart disease and death from COVID-19? In New Zealand multimorbidity is the norm[368] rather than a single disease state. Yet there are no tiny little fences compartmentalising each separate organ in the human body.

The absence of block funding and hypercompetitive funding environments have made the choices of f*unding committees* far more conservative, and this favours single disease-focussed, applied science. Panel members themselves, have navigated health-funding cultures which prioritise driving funding to scientific discovery which is likely to lead to innovations such as medical treatments or equipment. In this environment. deviant scientists who might seek to explore the drivers of disease, or adverse effects of a medical drug, will almost certainly remain unfunded. Funding is precarious, and internationally funding has been used to pressure scientists to obfuscate the Sars-Cov-2 lab leak hypothesis and deny ivermectin as a safe, antiviral treatment to prevent adverse outcomes in COVID-19.

It's been harder to occupy a critical role in the tertiary education system. For over 3 decades *New Zealand universities* have prioritised investment in the science, technology, engineering and mathematics (STEM) disciplines, while the Arts – where critical enquiry normally would reside, where the philosophers, the ethicists, the sociologists draw attention to hypocrisy, power and tyranny – have been systematically disenfranchised. For the economy-driven nation-state, the Arts does not promise the 'return' on investment the STEM disciplines promise.

For decades, the *public health profession* has pivoted to medical rather than social or political solutions. Today in New Zealand, health system indicators are predominantly tied to immunisation rates and access to medical care rather than prevention of metabolic disease or mental illness.[369] This directly depoliticises the traditional (and political) drivers of chronic disease and mental illness: poverty, stress and access to an optimum nutrition-based diet.[370] [371]

Review of how policy works, of the decision-making processes and institutional structures and cultures can help explain why New Zealand's high-level health system indicators do not emphasise primordial disease prevention (the prevention of a disease state). Instead, the system is devoted to primary prevention (such as detection and medical care); and the medical management of multiple disease states.

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[368] Millar, E., Dowell, A., Lawrenson, R., Mangin, D., & Sarfati, D. (2018). Viewpoint: Clinical guidelines: what happens when people have multiple conditions. *NZMJ*, 131(1472), 73-81. http://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2018/vol-131-no-1472-23-march-2018/7530

[369] Health System Indicators Framework. 13 December 2021 https://www.health.govt.nz/new-zealand-health-system/health-system-indicators-framework

[370] Marmot, M., & Allen, J. (2014). Editorial: The Social Determinants of Health Equity. *American Journal of Public Health*, 104(54) 5517-5519. https://doi.org/10.2105/AJPH.2014.302200

[371] Marmot, M. (2018). Medical Care, Social Determinants of Health, and Health Equity. *World Medical and Health Policy*, 10(2), 195-197. https://doi.org/10.1002/wmh3.261

10: YES, THE MEDICAL NARRATIVE IS POLITICAL

Lacking resourcing, expertise and stewardship, New Zealand will remain impotent to future claims of private and public institutions with either political and/or financial conflicts of interest.

In a recent presentation, an MBIE staffer stated that New Zealand's research, science and innovation system 'has been largely apolitical'. The production of science that draws attention to environmental drivers of human and environmental health harms is *directly* political. A culture that positions technology – including medical treatment – as the answer to social problems, jointly delegitimises those that might contest this perspective, while displacing and depoliticising the drivers of disease which are powerfully, undeniably political.

The weight of knowledge that supports a medicalised perspective encourages economic conflicts of interest because medicalisation is closely tied to drug development, approvals and regulatory decision-making. The same institution with a partnership with Pfizer will be unlikely to encourage research that is critical of Pfizer. In addition, the sheer weight of economy and innovation oriented, or 'market' science, dwarfs independent (publicly funded, common good) science, capturing publication and funding channels, and this perpetuates scientific cultures that reinforces a medicalised perspective. Innovation-centric health research shifts the scientific gaze away from the drivers of disease, making it difficult for advocates to fund scientific data that might provide evidence to drive regulation of a harm, or pull a product from the market.

These institutional practices produce not a health system, but rather, reinforce a chronic disease-based *medical* system. In New Zealand today, public health advocates, scientists and doctors would be largely out of health-policy scope if they researched the overarching environmental and institutional drivers of disease – the health effects of environmental (rather than behavioural) factors, such as ultraprocessed foods and obesity, or scientifically researching molecular level effects of vitamin D.[372] It would be similarly antithetical for a researcher to explore the propensity for unknown quantities of the spike protein to replicate inside the cell, and persist and damage the epithelium and induce clotting at a higher rate than the naturally acquired spike protein.[373] They might get funded once, but long-term research would be extraordinarily difficult, and their reputations could be at risk. Exploring adverse reactions is unwelcome in the current political environment, and Kevin Drew and Sarah Donovan have argued for increased transparency in public health, stating

> 'Public health can be upfront and transparent about the decisions made, the values they are grounded in, and any uncertainty around those decisions, so that people can have more confidence in vaccine policy.'

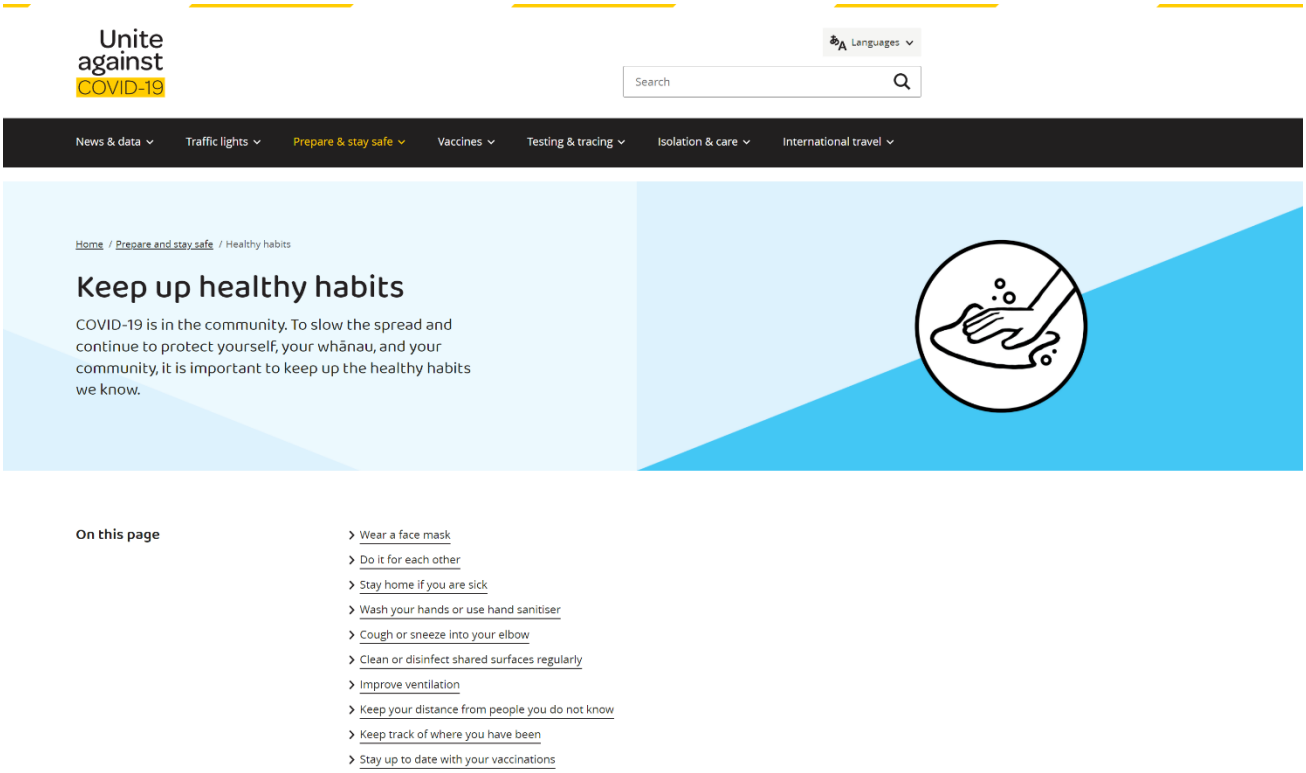
And adding:

> '… public health advocates can do more to engender trust. They could work to ensure that pharmacovigilance activities around vaccinations are rigorous, which may require actively seeking out concerns about vaccine reactions rather than passively receiving them, and that people's concerns are taken seriously and not dismissed. To engender trust, communication across divides should be fostered, rather than using or accepting polarising rhetoric. And as public health researchers we surely must not shy away from scrutinising vaccine policies, but we are best placed to take on the duty of interrogating vaccine policy and the efforts made to gain high levels of vaccine coverage (Dew, 2018), to ensure they are robust, fair, and convincing.'[374]

[372] Dror AA. et al. (2022). Pre-infection 25-hydroxyvitamin D3 levels and association with severity of COVID-19 illness. PLOS ONE, 17, 2, e0263069. https://doi.org/10.1371/journal.pone.0263069
[373] Demasi, M. (2022, Feb 15). COVID-19 vaccines: Is the spike protein "toxic" ? Blog. https://maryannedemasi.com/publications/f/is-spike-protein-%E2%80%9Ctoxic%E2%80%9D
[374] Dew, K. & Donovan, S. (2020) Vaccines, polarising divides and the role of public health. *Critical Public Health*. 30:1, 1-3, https://doi.org/10.1080/09581596.2020.1702286

'Market' science, lacking balance by the public sector inevitably fractures the fundamental infrastructure that democracy rests upon because there is no intellectual space for 'market' science to be challenged.[375] Democracy requires that decisions are made in the public interest, and that decision-making will be accountable and transparent. However, private, unpublished industry science is routinely prioritised and selected above and beyond any review of the published literature. It is therefore given asymmetrical weight in policy, that extends far beyond any independently funded, published, and peer-reviewed studies. Science is harnessed for economic gain, and disproportionately - for *private*, corporate, economic gain.

Sen and Nusbaum's capabilities approach, which drew attention to the often invisible (social, cultural, economic and environmental) barriers that make it disproportionately difficult for low-income groups to achieve well-being – applies here. With a health system that is principally medicalised, when a pandemic arises – following Sen and Nusbaum, there is no *capacity* – no expertise, no field of research nor quorum of scientists - that is sufficiently authoritative and buffered from potential political backlash – to advocate for ethics-based health protective policies. New Zealand's sole 'health' activity[376] has been to update nutrition guidelines,[377] however, exactly how low-income groups[378] will afford the recommended diet, remains out of scope. On the Unite Against COVID-19 Campaign site, healthy habits were connected to hygiene management, and no information relating to nutrition or diet were provided.



Health is not primarily determined by access to medication – health is political. Our health is powerfully and predominantly socially determined.[379] [380] Health is a function of environmental factors including culture, socio-economic status, public interest regulation and access to life-sustaining resources. Yet the social

[375] Michaels, D. (2020). The Triumph of Doubt. Dark Money and the Science of Deception. Oxford University Press. p.271
[376] New Zealand Ministry of Health Official Information Act request no. Response to your request for information (ref: H202110708) September 29th 2021.
[377] Ministry of Health (2020). *Eating and Activity Guidelines for New Zealand Adults.* Updated December 10, 2020. https://www.health.govt.nz/publication/eating-and-activity-guidelines-new-zealand-adults
[378] COVID-19 and maternal and child food and nutrition insecurity: a complex syndemic
[379] Marmot, M., & Allen, J. 2014. Editorial: The Social Determinants of Health Equity.
[380] Kivimäki, M. et al. (2020). Association between socioeconomic status and the development of mental and physical health conditions in adulthood: a multi-cohort study. *The Lancet*, 5(3), e140-e149. https://doi.org/10.1016/S2468-2667(19)30248-8.

determinants of health keep being excluded from government policy.[381] Medication can improve quality of life, but medication can also result in the perpetuation of illness as it enables symptoms to be ignored, and can dually *produce* illness through the collateral effects of polypharmacy and adverse reactions. The cost of multimorbidity is super-addictive – more illness escalates health costs and therefore profits.[382]

As this paper has discussed, poverty drives obesity and obesity is a powerful predictor for vulnerability from infectious disease, including COVID-19.[383] In New Zealand, 16% of children have obesity, and obesity is associated with a wide range of undiagnosed comorbidities in adolescents.[384] Covid-19 restrictions may have increased obesity.[385] After old age, the biggest driver of risk that an individual will be hospitalised or die from COVID-19 is their health status [386]– whether they are profoundly obese, have cardiac, neurological disorders and/or multiple health conditions.[387] [388] Indigenous populations including New Zealand Māori are disproportionately at risk.[389] [390] [391] Their health status is associated with their socioeconomic status – often driven by intergenerational poverty and racism. These groups tend to have high, concomitant levels of nutrient deficiency.

Not 'seeing' through medicalised cultures, can exacerbate injustice. Historically, public health directed efforts to helping poorer groups in society. Infectious disease tended to break out in low-socioeconomic neighbourhoods because the nutrition and housing were poor. [392] Today, the additional driver 'overnutrition' [393] from low cost and low value, calorific but nutrient-empty, low-fibre food – accelerates health-harm. These cascading dilemmas are both a cause and consequence of societies that appear unable to design precautionary policies which ensure immune systems are protected. Not being hungry, and being nourished, are two entirely different concepts.

Throughout COVID-19, not a single policy has been enacted to reduce inequality or increase access to safe and nutritious food. In fact, the opposite is true, e.g. incentives promoting vaccine uptake in communities with already high levels of obesity and other co-morbidities, included offers of free fast-food meals, such as KFC. These unethical strategies undermine decades of hard work delivering successful nutritional advice and educational interventions. In New Zealand, the life of low-income groups have become more precarious, as wage increases[394] lag behind the cost of living.[395] This has been demonstrated globally.[396]

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[381] Baker et al. 2018. What Enables and Constrains the Inclusion of the Social Determinants of Health Inequities..
[382] Blakely, T. et al. (2019). Health system costs for individual and comorbid noncommunicable diseases: An analysis of publicly funded health events from New Zealand. *PLOS Medicine*, 16(1), e1002716. https://doi.org/10.1371/journal.pmed.1002716
[383] Mohammad, S. et al. (2021). Obesity and COVID-19: what makes obese host so vulnerable? *Immunity & Ageing.* 18(1), https://doi.org/10.1186/s12979-020-00212-x
[384] Leong K.S.W. et al (2020). High prevalence of undiagnosed comorbidities among adolescents with obesity. *Nature Scientific Reports.* 10, 20101 https://doi.org/10.1038/s41598-020-76921-6
[385] Stavridou A. et al. (2021). Obesity in Children and Adolescents during COVID-19 Pandemic. *Children*, 8, 135, https://doi.org/10.3390/children8020135
[386] Belanger, M.J. et al. (2020). Covid-19 and Disparities in Nutrition and Obesity. *NEJM.* 383:e69. https://doi.org/10.1056/NEJMp2021264
[387] Korakis, E. et al. (2020). Obesity and COVID-19: immune and metabolic derangement as a possible link to adverse clinical outcomes. *Am J Physiol Endocrinol Metab.* 319(1), E105-E109. https://doi.org/10.1152/ajpendo.00198.2020
[388] Michalakis, K. & Ilias, I. (2020). SARS-CoV-2 infection and obesity: Common inflammatory and metabolic aspects. *Diabetes & Metabolic Syndrome*, 14(4), 469-471. https://doi.org/10.1016/j.dsx.2020.04.033.
[389] Ministry of Health (2018). *Health and Independence Report 2017.*
[390] Reynolds, D. et al. (2020). Food and vulnerability in Aotearoa/New Zealand: A review and theoretical reframing of food insecurity, income and neoliberalism. *New Zealand Sociology* 35(1), 123-152. https://ourarchive.otago.ac.nz/handle/10523/10873
[391] Steyn, N. et al. (2021). Māori and Pacific people in New Zealand have a higher risk of hospitalisation for COVID-19. *NZMJ*
[392] Rosen, G. (1958). *A history of public health.* New York: MD Publications.
[393] Jaacks, L.M. et al. (2019). The obesity transition: stages of the global epidemic. *Lancet Diabetes Endocrinol.* 7(3), 231-240. https://doi.org/10.1016/S2213-8587(19)30026-9
[394] StatsNZ (2022, Feb 2). Unemployment rate at 3.2 percent. February 2, 2022. StatsNZ. https://www.stats.govt.nz/news/unemployment-rate-at-3-2-percent
[395] Dickinson P. (2021, April 21). 'Perfect storm': Cost of living rises 0.8 percent, tipped to increase further. *Newshub.* https://www.newshub.co.nz/home/money/2021/04/perfect-storm-cost-of-living-rises-0-8-percent-tipped-to-increase-further.html
[396] Pérez-Escamilla, R. et al. (2020). COVID-19 and maternal and child food and nutrition insecurity: a complex syndemic. *Maternal and Child Nutrition*, 16(3), e13036. https://doi.org/10.1111/mcn.13036

It's not that there is a balanced approach. Research and health policy on the social determinants of health and disease have for decades, been *dwarfed* by investment in medical technologies. Short term incentivisation of economic return is much more compelling to policy-makers than long-term changes, as Skegg pointed out prior to Covid. However, these challenges can be overcome.

The suppression of investment in academia, policy and research results in an advocacy chasm for health (rather than medical) justice. The suppression of investment to explore the social, nutritional, technological and environmental drivers of modern-day disease, means that institutional activities and conflicts of interest as drivers of disease are *not challenged*. New Zealand's academic, policy and research deficit directly produces blinkered policy across the machinery of government, and it has never been more evident than in COVID-19.

It ensures that it is politically, economically and practically impossible to prepare for the next pandemic.

Precarious and inadequate long-term funding to promote local, long-term public good research on interlocking issues of governance, risk, ethics and technology produces a technocratic instrumentalism that can be observed in COVID-19 management and the narrow capture of modelling as a means to justify policy and legislation. It means that scarce few public employees will raise an issue that is likely to promote uncertainty and therefore be controversial. Denial of a safe space to consider values, ethics, science and technology means that this work won't be undertaken. So therefore, no scientists were tasked to independently review the published literature and stratify risk from either COVID-19 or the mRNA technology by age or health status. Issues of outcome reporting bias [397]remain unaddressed. Pharmaceutical treatment recommendations are baked-in,[398] and justified by data supplied by outside jurisdictions. This sits alongside a policy environment that directs funding to technology and directly *away* from research – and knowledge - that might critique and steward the much-vaunted technology *in the public interest.*

This generates more dilemmas. To those *outside* the medicalised paradigm, these medicalised cultures appear ideological and unjust. To those *inside* the medicalised paradigm, the political and ethical implications can be over-whelming or 'unpractical' and dripping with uncertainty.

11: THE CAPTURE OF THE MEDIA & THE JUDICIARY

Democracies are only as robust as the institutions tasked to hold power to account. Neither media nor the judiciary have critically analysed 2 key issues – whether the legislation and orders were appropriate to risk iterated in the scientific literature at the time of implementation of those legislation and orders; and whether the battery of legislation (See Note 1) enacted by government ministers and the Parliamentary Counsel Office was possibly ultra vires. The legislation set in place a case chase and case fear narrative, leaving out the obligation to protect and promote health, and traditional principles of infectious disease and in the process, dispensing with the principle of informed consent.[399] Were institutional checks appropriate, or was the excess of law-making far in excess of identified risk in the scientific literature. An excess of law-making often spells trouble, eliding democratic norms of accountability and transparency for, 'the more corrupt the state, the more numerous the laws.'[400]

Two years into the pandemic, New Zealand's media, captured by the first financial windfall in three decades, remain neutered, a fourth estate that cannot hold power to account. The following issues remain largely unaddressed in court cases or by the accredited media:

[397] Brown R.B. (2021). Outcome Reporting Bias in COVID-19 mRNA Vaccine Clinical Trials. *Medicina*, 57(3),199. https://doi.org/10.3390/medicina57030199
[398] Ministry of Health (2021, Jul 9) COVID-19 Science Updates. Report https://www.health.govt.nz/system/files/documents/pages/csu_09_july_2021_covid-19_pharmaceutical_treatments.pdf
[399] PCO. Health Act 1956. Part 3A Management of infectious diseases. 92A Principles to be taken into account https://www.legislation.govt.nz/act/public/1956/0065/latest/whole.html#DLM305840
[400] Roman historian Tacitus (55-120 AD). The Annals of Imperial Rome.

- Whether representations by the Crown in judicial review relating to mandates, first, misled the judiciary into conflating the safety profiles of genetic vaccines with conventional vaccines; and second, did not appropriately and transparently review the peer reviewed, scientific literature as befits the obligations of the Crown to protect the public.
- Does the *absence* of analysis of peer reviewed, evidence based science in government literature to support policy and lawmaking, and the reliance on local modelling strategies (funded by the agency with interest in the rollout of the emergency response strategy) present an alarming tactical precedent for deployment in future emergencies, such as pandemics?
- Do the mandates tied to acceptance of a novel mRNA technology, where the government was not reviewing the scientific literature on risk, raise legal and ethical dilemmas of constitutional morality, natural justice and human rights, and what precedent does this set for future pandemics?
- By ignoring the role of scientifically established role of broad-based immunity in modelling scenarios did the Crown deviate public health norms in such a way as to endanger the New Zealand population?
- Did Medsafe fail to protect the population by first, not requiring compulsory reporting of adverse events and death; and second, by not drawing attention to the disproportionate risk of not-at risk from COVID-19 groups from exposure to the novel medical intervention?
- Did the conflating of groups who died *with* or *because of* COVID-19 increase fear in the population.
- Has appropriate record-keeping of the status individuals who were hospitalised or die with COVID-19 occur? Inflammatory and/or metabolic conditions; nutrient status, including vitamin D levels; and blood glucose are risk factors for adverse outcomes identified in the scientific literature.
- Masking in educational institutions does not protect students who are not at risk of hospitalisation and death; and in April 2022 mask rules continue despite Omicron surging through all secondary and tertiary institutions. How could legislation requiring young people to wear a mask 6-8 hours a day remain unquestioned with evident policy failure?
- Which analysts and scientists in New Zealand are now tasked with assessing long-term societal costs from lifetime disability or death following genetic vaccination, and ensuring adequate compensation?

12: DOCTORS: LINED UP & SUSPENDED FOR PRACTICING INFORMED CONSENT

The culture that can be observed across the health system has provided the environment for the Medical Council of New Zealand (MCNZ) to declare that they have 'zero tolerance' [401] for so-called 'anti-vax' messages.

The implication of the MCNZ making such a statement is alarming, as part of the MCNZ's are tasked with ensuring that the New Zealand public are not put at risk from exposure to unsafe medicine or inappropriate medical treatment that doesn't reflect patient needs. The MCNZ's stance, infers that informed consent and medical autonomy can no longer be taken for granted. Their stance has ruptured their role as regulator of the social contract between the doctor and patient, that is underpinned by the maxim 'first, do no harm'.

The MCNZ's actions send a further chilling message, that state-mandated medication must be accepted, that the MCNZ are not an independent arbiter, and that neither the doctor nor patient have latitude to question the decision of the state, no matter the provenance nor safety profile of a medical intervention.

[401] RNZ (2021, Oct, 8). Medical Council has 'zero tolerance' for anti-vax messages from doctors as it receives 23 complaints. https://www.rnz.co.nz/news/national/453145/medical-council-has-zero-tolerance-for-anti-vax-messages-from-doctors-as-it-receives-23-complaints

Several doctors have had their license suspended after their COVID-19 behaviour and views have been reported to the Medical Council. In the 2020-2022 COVID-19 pandemic, in New Zealand, doctors have been brought before the Medical Council of New Zealand because they have insisted on discussing the infection fatality rate as it relates to their patient in a given age range; for discussing the potential for the mRNA genetic vaccine to cause harm; for transparency on the short-circuiting of safety trials; and for suggesting vaccine alternatives. In an April 2021 decision two suspended doctors have won district court appeals, but the MCNZ may appeal the decision.[402]

The principle of 'first do no harm' is foundational to medical ethics and reduces risk from overtreatment.

Most, if not all of these doctors have been operating medical clinics that have vaccinated their populations for three decades or more. However, through their insistence on practicing informed consent and their caution over a novel mRNA genetic vaccine, they have been misleadingly shamed as anti-vaxxers. This strategy of discrediting clinical and public health experts has been a phenomenon repeated across the globe during the pandemic.

The informed consent process helps people of all risk profiles assess their relative risk to a medical treatment. This is normally a process undertaken for medical treatments that have had years of use, with well recognised safety profiles. The principle of informed consent was in place to stop people from having medication they do not need. It also appears that risk was not appropriately communicated when the public were at a site of administration of the genetic vaccine. The mRNA genetic vaccine did not have a legacy safety profile, and this was highlighted in an open letter by New Zealand Doctors Speaking out with Science (NZDSOS).[403] The NZDSOS New Zealand public should be informed of the absolute risk, their potential for hospitalisation and death by age and multimorbid status – following infection from Sars-Cov-2 – *versus* their risk of hospitalisation death from the mRNA genetic vaccine. The open letter iterated that the state had not taken steps to make the infection fatality rate transparent, even though risk was stratified by age, and so people could not understand the risk-benefit ratio, in addition, the status of previously infected people was never discussed.

The public cannot conduct an Official Information Act (OIA) request to the MCNZ, a democratically unaccountable institution, to all appearances. There is no clear complaints mechanism and anonymous complaints are accepted (which reduces transparency and accountability).

The combined power of the machinery of government, the media and the Medical Council of New Zealand has resulted in doctors who have vaccinated their populations for over 30 years, shamed as 'anti-vaxxers' – when they are instead, simply insisting on their patients' rights to maintain informed consent.

The culture of medicalisation, the emergency approval, and the apparent predetermination that all people will receive the genetic vaccine, has enabled authorities to evade historically required processes that ensure safety. There is no requirement for mandatory reporting of adverse incidents including hospitalisation, disability and death; there are no years of safety data to support injection of the genetic vaccine into pregnant women, infants, and children and healthy young people.

It's also evident that the COVID-19 pandemic has been a financial blessing for clinicians who might be struggling with the economic costs of financing medical education, or onerous mortgages on medical clinics. While the following information has not been confirmed with the relevant institution, each nasal swab was alleged to return $135 per person; a visit to a vehicle dressed in full personal protective equipment to return $250. A total of $385 per person. A visit to a car with two symptomatic people would return $770. This was

[402] Olley, S. (2022,April, 1). Doctors suspended over anti-vax claims win court appeals. *RNZ,* https://www.rnz.co.nz/news/national/464442/doctors-suspended-over-anti-vax-claims-win-court-appeals
[403] NZDSOS (2021, June 14). The need for true informed consent for the Pfizer Cominraty COVID-19 vaccination. https://nzdsos.com/2021/06/14/open-letter-on-informed-consent/

not only financially lucrative, but doctors were incentivised to declare patients were symptomatic, if they were to be paid.

13: APPROPRIATING THE AGENCY OF MEDICAL EXPERTS

There is no doubt the New Zealand state expected genetic vaccine compliance across the nation, regardless of age-stratified risk. The COVID-19 Vaccine Immunisation Programme Service Standards stated 'COVID-19 Vaccine has been secured for everyone in New Zealand/Aotearoa aged 12 years and over to receive the two doses they need to protect against COVID-19'[404] and the Medical Council of New Zealand declared that there was 'no place for anti-vaccine messages' or ' promotion of anti-vaccine claims'.[405] It mattered not to the Medical Council of New Zealand that vaccination historically prevented transmission and infection from an infectious disease; nor that the novel genetic vaccine technologies were provisionally approved because they lack full clinical trial data to confirm safety.

The 'deviant' doctors, through the insistence on applying the practice of informed consent (institutionalised in law,[406] via the Belmont Report,[407] the Code of Health and Disability Services Consumers' Rights[408]) directly challenged government dogma that presumes all people should accept a provisionally approved, mRNA genetic vaccine, and then stepwise agree to vaccine passports.

Globally, these physicians further challenged the power of the New Zealand state when they discussed alternative treatment options which include multitarget medical and nutritional treatments[409] from repurposed drugs with a long history of safe use. COVID-19, as with HIV/AIDs, is a complex disease requiring complex treatment protocols.

State institutions effectively expunged the personal agency of frontline medical personnel by exhorting doctors[410] to conform; by focussing on cases rather than hospitalisation rates[411]; conflating doctors guidance with 'personal beliefs'[412]; ignoring mRNA gene therapy risk by age group; discouraging repurposed drugs[413] that produce an integrated response to the complex pathologies[414] present in COVID-19; and by ignoring nutritional and other lifestyle therapies,[415] [416] particularly useful to buffer lower-socioeconomic groups at greater risk of immune-related nutrient-deficiency.

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[404] Ministry of Health (2021, Sept). COVID-19 Vaccine Immunisation Programme Service Standards. https://www.health.govt.nz/system/files/documents/pages/covid-19-vaccine-immunisation-programme-service-standards-29oct2021.pdf

[405] MCNZ (2021, Aug 20) Media release - Medical Council of New Zealand. https://www.mcnz.org.nz/about-us/news-and-updates/media-release/

[406] Appelbaum, P.S. et al. (1987). *Informed Consent: Legal Theory and Clinical Practice.* Oxford University Press,

[407] The Belmont Report Office of the Secretary. Ethical Principles and Guidelines for the Protection of Human Subjects of Research. The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. https://www.hhs.gov/ohrp/regulations-and-policy/belmont-report/read-the-belmont-report/index.html

[408] Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996. https://www.hdc.org.nz/your-rights/about-the-code/code-of-health-and-disability-services-consumers-rights/

[409] Ngo, B.T. et al. (2021). The time to offer treatments for COVID-19. *Expert Opin Investig Drugs,* 20(5), 505-518. https://doi.org/10.1080/13543784.2021.1901883

[410] Dental Council (u.d). Guidance statement COVID-19 vaccine and your professional responsibility. https://www.mcnz.org.nz/assets/standards/Guidelines/30e83c27d9/Guidance-statement-COVID-19-vaccine-and-your-professional-responsibility.pdf

[411] Ministry of Health and New Zealand Government (2022, Jan). *Immunisation Handbook.* P.156

[412] Medical Council of New Zealand (2021, Nov). Good Medical Practice. https://www.mcnz.org.nz/assets/standards/b3ad8bfba4/Good-Medical-Practice.pdf

[413] Medsafe (2021, Sept 6). Risks of importing or prescribing ivermectin for prevention or treatment of COVID-19. https://www.medsafe.govt.nz/safety/Alerts/ivermectin-covid19.htm

[414] Marik, P.E. et al. (2021) A scoping review of the pathophysiology of COVID-19. *International Journal of Immunopathology and Pharmacology*, 35, 20587384211048026 https://doi.org/10.1177/20587384211048026

[415] Clemente-Suárez V.J. (2021). Nutrition in the Actual COVID-19 Pandemic. A Narrative Review. *Nutrients*, 13, 1924, https://doi.org/10.3390/nu13061924

[416] Costagliola, G. et al. (2021). Could nutritional supplements act as therapeutic adjuvants in COVID-19? Italian Journal of Pediatrics, 47, 32, https://doi.org/10.1186/s13052-021-00990-0

What can be observed in New Zealand, is the power of the state in full roar. Cabinet, the Ministry of Health, Pharmac, MedSafe, the drafters of legislation, the funded media (and media watchdogs), the silent and compliant universities and the Medical Council of New Zealand. These institutions have effectively operated in concert to shepherd all to genetic vaccine compliance and produce and sustain ignorance and control the political narrative.

Agreements with the manufacturer further impeded transparency. Secret (commercial in confidence[417]) government contracts with the mRNA genetic vaccine supplier made it difficult to understand what data was supplied in support of the technology. It remains unknown whether there is a potentially chilling effect arising from international trade agreements, such as the Comprehensive and Progressive Agreement for Trans-Pacific Partnership (CPTPP) should contracts be suspended.

Doctors dealing with complex conditions normally exercise personal agency, personal judgement in order to make the best decision for their patient. Conventionally, repurposed drugs, such as the antiviral Ivermectin, would be widely used in multiple scenarios, with doctors given latitude to make such decisions. However, COVID-19 clinical guidelines have steered clinicians away from such practices. [418] [419] The state has never before restricted access to traditionally safe off-label use of an historically safe drug. Restrictions, policies and guidelines across government institutions can be observed to act in concert, and ultimately produce multiple forms of ignorance that place the public at risk of hospitalisation and death – because they remove agency and discretion from doctors.

The policies discussed in this paper render as precarious, judgements outside guidelines which are normally common in practice. The statements and warnings delivered by government institutions have produced a chilling effect across the health field. This institutional power has captured hospital medics, ambulance medics and medical practices through an overarching culture and instrumental policy that cannot judge and weigh risk differently – and respond to the needs of an individual patient - without risking the consequences of a report to authorities that may result in social, professional and/or political ostracism.

Narrowly derived, dictated protocols perpetuates a learned helplessness, a ‘nescience’ – that by restricting agency removes autonomy and learning in the practice of medicine. These protocols promote impotence and anxiety of ramifications should they step outside clinical guidelines and be reported to the MCNZ.

Medicine is a notoriously conservative profession, and the public shaming of the dissident medical doctors has been loud and clear. Radio New Zealand has led in describing doctors as ‘anti-vax’ for expressing caution concerning the novel mRNA treatment and attempting to support patients that that were forced to have the genetic vaccine in order to secure their jobs. [420] [421] [422] These doctors had worked for decades in isolated rural communities. Health providers normally struggle to get long term doctors in isolated communities.

14: WILL THE COURTS DECIDE?

Perhaps one of the most important questions that courts will decide, is whether state actors, including New Zealand’s Medsafe, caused harm and increased the rate of hospitalisation and death by deliberately preventing access to historically safe, preventative treatments? Did this action constitute a form of regulatory capture, that disproportionately benefitted offshore financial interests? Was the suppression of knowledge concerning the

[417] See for example, rejected request for access to Pfizer agreement. Official Information Act request no. H202110481. https://fyi.org.nz/request/17050-request-for-pfizer-agreement-with-new-zealand-government#comment-4530
[418] Ministry of Health (2021, Jul 9). Science Update.
[419] Ministry of Health (2022, Feb, 4). Clinical Management of COVID-19 in Hospitalised Adults (including in pregnancy). https://www.health.govt.nz/system/files/documents/pages/clinical_management_of_covid-19_in_hospitalised_adults_2.pdf
[420] Olley, S. (2022, Jan 17). Covid-19: Anti-vax GP speaks out against doctor who reported him. RNZ. https://www.rnz.co.nz/news/national/459674/covid-19-anti-vax-gp-speaks-out-against-doctor-who-reported-him
[421] RNZ (2021, Dec 10). Less than 30 antivax GPs in NZ, college estimates. RNZ. https://www.rnz.co.nz/national/programmes/checkpoint/audio/2018824103/less-than-30-antivax-gps-in-nz-college-estimates
[422] Olley, S. (2021, Oct 7). Vaccine opposition in Te Tai Tokerau driven by misinformation - DHB head. RNZ. https://www.rnz.co.nz/news/national/453064/vaccine-opposition-in-te-tai-tokerau-driven-by-misinformation-dhb-head

potential for early treatments to prevent hospitalisation and death directly related to securing political and regulatory support granting provisional licences for never-prior-approved novel genetic vaccines.

Early treatments, utilising nutriceuticals and repurposed drugs with a long history of safe use were demonstrated to lead to a reduction in hospitalisation and death as early as 2020.[423] [424] [425] [426] [427] [428] However, these have not been recommended in clinical guidelines in New Zealand[429] [430] [431], where recommended treatments including tocilizumab[432] [433], dexamethasone[434], remdesivir[435] [436] [437] and molnuprivar[438] which have significantly less historic data supporting their safety; while also having limited data proving reduction of hospitalisation and death. Less expensive off-patent early treatments have a longer safety record.[439] [440] [441] [442] [443]

The courts will also be interested in whether the signature provided by the New Zealand public on receipt of injection constitutes a waiver of criminal liability of the state, i.e., whether the signature can legally infer that the public were aware of the degree of risk from the medical intervention. This is closely related to the principle of informed consent, which has historically required that the public recognise the potential risk from the medication that they take into their body.

It is hoped that the courts will draw attention to the importance of well-established, recognised principles of infectious disease, that recognise autonomy and proportionality in health care[444] that were disbanded from 2020-2022. The result is that the richest generation, the baby boomers, have been disproportionately

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[423] McCullough, P.A. et al. (2020) Multifaceted highly targeted sequential multidrug treatment.
[424] Association of American Physicians and Surgeons. January 2022 Physician List & Guide to Home-Based COVID Treatment. https://aapsonline.org/covidpatientguide/
[425] Canadian Covid Care Alliance. Early Treatment Protocols. https://www.canadiancovidcarealliance.org/treatment-protocols/
[426] World Council for Health (2021, Sept). Early Covid-19 treatment guidelines: A practical approach to home-based care for healthy families. https://worldcouncilforhealth.org/resources/early-covid-19-treatment-guidelines-a-practical-approach-to-home-based-care-for-healthy-families/
[427] Front Line COVID-19 Critical Care Alliance. Prevention & Treatment Protocols for COVID-19. https://covid19criticalcare.com/covid-19-protocols/
[428] Alexander P.E. et al. (2021). Early ambulatory outpatient sequenced antiviral multidrug COVID-19 treatment (including for Delta or similar variants) for high-risk children and adolescents. https://scholarworks.utrgv.edu/mss_fac/195/
[429] Ministry of Health (2021, Jul 9). Science Update.
[430] Ministry of Health (2022, Feb, 4). Clinical Management of COVID-19 in Hospitalised Adults (including in pregnancy). https://www.health.govt.nz/system/files/documents/pages/clinical_management_of_covid-19_in_hospitalised_adults_2.pdf
[431] Starship Hospital (2022, Feb 24). COVID-19 disease in children https://starship.org.nz/guidelines/covid-19-disease-in-children/
[432] Rosas, I.O. et al. (2021). Tocilizumab in Hospitalized Patients with Severe Covid-19 Pneumonia. *NEJM*, 384,1503-16. https://doi.org/10.1056/NEJMoa2028700
[433] Cortegiani, A. et al. (2021). Rationale and evidence on the use of tocilizumab inCOVID-19: a systematic review. *Pulmonology* 27(1), 52-66. https://doi.org/10.1016/j.pulmoe.2020.07.003
[434] Noreen, S. et al. (2021). Dexamethasone: Therapeutic potential, risks, and future projection during COVID-19 pandemic. *European Journal of Pharmacology*, 894, 173854. https://doi.org/10.1016/j.ejphar.2021.173854
[435] O Gérard, A.O. et al. (2021). Remdesivir and Acute Renal Failure: A Potential Safety Signal From Disproportionality Analysis of the WHO Safety Database. *Clin Pharmacol Ther*. 109(4), 1021-1024. https://doi.org/10.1002/cpt.2145
[436] Nabati, M. & Parsaee, H. (2021). Potential Cardiotoxic Effects of Remdesivir on Cardiovascular System: A Literature Review. *Cardiovasc Toxicol*, 13, 1-5. doi: https://doi.org/10.1007/s12012-021-09703-9.
[437] Efimenko I. et al. (2022). Treatment with Ivermectin Is Associated with Decreased Mortality in COVID-19 Patients: Analysis of a National Federated Database. Int. J. Inf. Diseases, 116, s40. https://doi.org/10.1016/j.ijid.2021.12.096
[438] Kabinger, F. et al. (2021). Mechanism of molnupiravir-induced SARS-CoV-2 mutagenesis. *Nature Structural & Molecular Biology*, 28, 740-246. https://doi.org/10.1038/s41594-021-00651-0
[439] Kerr, L. et al. (2022). Strictly regular use of ivermectin as prophylaxis for COVID-19 leads to a 90% reduction in COVID-19 mortality rate, in a dose-response manner: definitive results of a prospective observational study of a strictly controlled 223,128 population from a city-wide program in Southern Brazil. Cureus, 14(1), e21272. https://doi.org/10.13140/RG.2.2.20069.68320
[440] Hcqmeta Database. Hydroxychloroquine for COVID-19: real-time meta analysis of 319 studies. Covid Analysis. February 15, 2022. https://hcqmeta.com/
[441] Database of all ivermectin COVID-19 studies. 148 studies, 98 peer reviewed, 78 with results comparing treatment and control groups. February 15, 2022 https://c19ivermectin.com/
[442] Dror, A.A. et al. (2022). Pre-infection 25-hydroxyvitamin D3 levels and association with severity of COVID-19 illness. *PLoS One*, 17(2), e0263069. https://doi.org/10.1371/journal.pone.0263069
[443] Tyson B & Fareed G. (2021). *Overcoming the COVID-19 Darkness: How Two Doctors Successfully Treated 7000 Patients.* Self-published book.
[444] PCO. Health Act 1956. Part 3A Management of infectious diseases. 92A Principles to be taken into account

protected, while (on average) poorer, under 65's have been coerced to accept a medical intervention, in order to participate in economic and social life.

To what degree was the pandemic designed and overseen by individuals and institutions financially and politically incentivised to drive mass acceptance of genetic vaccines, and mass acceptance of track and trace digital identification systems to the detriment of human rights and individual privacy?[445] [446]

The courts will settle these questions in time.

CONCLUSION: PUBLIC (NOT MEDICAL) HEALTH REQUIRES A ROBUST DEMOCRACY

This paper concludes that the combination of rapid output of legislation and flawed policy process have produced deficient COVID-19 legislation that was never democratically accountable. This paper suggests that all COVID-19 legislation is repealed and provisional consent for mRNA genetic vaccines is withdrawn.

The triple tragedy of this pandemic, is that those that wanted to develop a natural immunity buffer from natural infection, were refused this opportunity, on pain of economic and social exclusion. Not at-risk groups were forcefully coerced to accept risk of adverse harm from the novel mRNA technology that skipped most of the clinical trials normally required to assure public safety. Finally, those who were at risk were not given the choice of early multitarget treatment that might have reduced their risk of hospitalisation and death.

The Unite Campaign has demanded that everyone must be vaccinated to protect the vulnerable, even if the mRNA genetic vaccine could not assure prevention of hospitalisation and death, as vaccine waning occurs differently by age and health status. The demand (and mandate coercion) shepherded Kiwis to accept the novel medical intervention and police the perceived 'vaccine status' of those around them. The assumption of global vaccination appears to have been embedded in policy from the earliest stages, when contracts were first signed for (at least) 2 doses of the Pfizer BNT162b2 genetic vaccine for every citizen, and when papers advancing the elimination strategy were published.

The novel mRNA genetic vaccine had a dubious, if not terrible, safety record from the first 6 months of data production that conventionally would have prevented authorisation of the drug.

In the absence of early treatment, a state-manufactured Catch-22 dilemma continues to be imposed on vulnerable groups at most risk from COVID-19 and of vaccine failure from the now out of date genetic vaccine. For the aged and infirm and for those suffering from severe and overlapping multimorbidities, mRNA vaccination is *of the essence* because there is no public recognition of other options. Yet vulnerable people may experience vaccine failure within a relatively short period of time, [447] and they may be more at risk of an adverse event from the mRNA treatment. Without the knowledge of home-based early treatments can prevent hospitalisation and death, these people have every right to be terrified and defensive if questions are raised by 'outsiders' regarding the safety and efficacy of the mRNA gene therapy.[448]

As Sars-Cov-2 continues to circulate, the respiratory virus may be reducing in pathogenicity due to increasing natural immunity, or it may be increasing in pathogenicity as it infects vaccinated people with weaker immune systems. But our science system is not set up to do controversial research.

This paper recommends a public pivot, to establish policy that prioritises the developmental origins of health and disease; and officially recognises that dominant single disease narratives which underpin policy, medical

[445] Du, L. et al. (2009). The spike protein of SARS-CoV — a target for vaccine and therapeutic development. *Nat Rev Microbiol.*, 7(3), 226–236. https://doi.org/10.1038/nrmicro2090
[446] Kennedy, R.F. (2021) *The Real Anthony Fauci: Bill Gates, Big Pharma, and the Global War on Democracy and Public Health. Child.* Skyhorse Publishing
[447] Nordström, P. et al. Effectiveness of Covid-19 Vaccination Against Risk of Symptomatic Infection, Hospitalization, and Death Up to 9 Months: A Swedish Total-Population Cohort Study. *The Lancet*, https://doi.org/10.1016/S0140-6736(22)00089-7
[448] Alexander, P.E. (2022, Jan 22). Early Outpatient Treatment for COVID-19: The Evidence. Brownstone Institute. https://brownstone.org/articles/early-outpatient-treatment-for-covid-19-the-evidence/

practice and scientific research in health are profoundly misleading. Multimorbiditiy is the norm in New Zealand today. Chronic disease commonly entails a cascade of overlapping health conditions that are driven by early childhood, poor political and regulatory stewardship of technologies and pollution, and inequality. Whether for *communicable* or *non-communicable* disease, being aged and infirm and suffering from severe and overlapping multimorbidities, are the primary drivers of hospitalisation and death.

Understanding how the state co-opted institutions to support the Unite Campaign, while placing a chill on dissidents is critical if civil society is to remain safe from exploitation, and democratic nations are to remain resilient and democratically accountable. Accelerating deployment of technologies at global scale and digitisation, and the difficulty in ensuring transparency and accountability from opaque technologies create opportunities for appropriation of power by large institutional interests at a cost of democratic life and rights protection.

Lacking awareness and implementation of independent research and analysis to inform policy, the biggest concern is the precedent the Unite Against Covid tactics create for future pandemic scenarios. New Zealand's response must be independent and there must be robust debate, in order to counter powerful local and global narratives of those with vested financial and political interests. In December, talks commenced for an 'historic global accord on pandemic prevention, preparedness and response.'[449] However there are concerns that digital identity systems, close relationships with digital software providers and pharmaceutical industries may result in the WHO's proposal being more about surveillance and control and less about the protection of health and prevention of hospitalisation and death.

The World Health Organisation is increasingly financially dependent on private interests who often earmark donations, dictating the WHO's priorities and action agenda.[450] The non-profit GAVI has outsize influence on the WHO and GAVIs policy interests are closely tied to GAVIs private funders.[451] Entrepreneur Bill Gates is viewed as having outsize interest through the Bill and Melinda Gates Foundation and his interests directly concern the deployment of technology, rather than the conventional concerns of public health authorities, including the protection of local food systems, drinking water and wellbeing. The Gates foundation ties donations to specific agendas the WHO is required to comply with; the foundation funds GAVI and the foundation set up COVAX.[452][453] In addition, the large vaccine developers' group COVAX, an effective 'vaccine buyers' and distribution club' are intricately tied into and partner policy development with institutions including the World Bank and the World Health Organization. These players are incentivised to situate risk as a medical solution rather than health-based solution.[454] COVAX has been described as a 'super public private partnership' focussed on the single disease, 'privilege technological solutions over attention to health systems and structural determinants of health, monitor themselves, and heavily advocate their own successes.'[455]

In addition, other global initiatives led by private charities frequently lack the transparency of publicly developed global agencies. The World Government Summit Organization has been put in place to 'shape the future of governments' – to influence policy. Focus is not on democracy, but on technology, trade, security and surveillance. The World Government Summit brings together powerful actors, including the World

[449] WHO (2021, Dec 1). World Health Assembly agrees to launch process to develop historic global accord on pandemic prevention, preparedness and response. https://www.who.int/news/item/01-12-2021-world-health-assembly-agrees-to-launch-process-to-develop-historic-global-accord-on-pandemic-prevention-preparedness-and-response

[450] Reddy, SK., et al (2018). The financial sustainability of the World Health Organization and the political economy of global health governance: a review of funding proposals. *Globalization and Health. 14, 119*

[451] Bruen, Carlos (2018): Politics & Policy Processes of Global Health Partnerships: The Case of Gavi, the Vaccine Alliance. Royal College of Surgeons in Ireland. Thesis. https://doi.org/10.25419/rcsi.10802996.v1

[452] McGoey, L. (2016). No Such Thing as a Free Gift: The Gates Foundation and the Price of Philanthropy. *Verso.*

[453] SwissInfo (2021, May, 10). Does Bill Gates have too much influence in the WHO? https://www.swissinfo.ch/eng/does-bill-gates-have-too-much-influence-in-the-who-/46570526

[454] Stein, F. (2021). Risky business: COVAX and the financialization of global vaccine equity. *Globalization and Health, 17, 112,* 8, S5, https://doi.org/10.1186/s12992-021-00763-8

[455] Storeng KT. Et al (2021). COVAX and the rise of the 'super public private partnership' for global health. *Global Public Health*, https://doi.org/10.1080/17441692.2021.1987502

Economic Forum, and Trade Organization, and members include all the large institutional advisors including Deloitte, Accenture, McKinsey and Company and BCG.[456] [457]

The World Economic Forum (WEF) is dedicated to shaping the 'global agenda' and 'advance progress' and have 'no commercial interest', yet it's influence on global governance does not extend to iterating the challenge for democracy in navigating an increasingly opaque and privatised technological world.[458] The WEF board and member organisations reflect private interests. Focus is on digitization and technological revolution, however, if global digital platforms lack a robust framework of transparency and autonomy, private institutions will exert outsize influence, to the disadvantage of more complex issues relating to human rights, and human and environmental health.

In closing, twelve major themes have been identified in this paper, that suggest how overlapping cultures, norms and ways of operating, enabled the COVID-19 rollout to be deployed to the detriment of democratic and public health norms. These themes draw attention to the application of strategic tactics that limited the rights of New Zealanders, produced extensive health harms and eroded public trust in governance institutions.

The 12 themes are summarised as follows:

1. **Narrow interpretations of science have been harnessed.** Internal modelling shaped risk to secure public consent and justify restrictive laws and mandates, while peer reviewed science drawing attention to uncertainty and risk was ignored.

2. **Fundamental and historically recognised public health norms have disintegrated.** Principles of public health recognise that society must both protect aged and vulnerable populations, *and* the young and healthy. The principle of informed consent is in place to balance individual risk from medication.

3. **Discussion of erosion of democratic norms will always be complex.** The overarching legislation was not publicly consulted upon before receiving Royal Assent but established the legislative platform for an unprecedented expansion of powers. The Hon David Parker put the driving legislation in place; however, as Attorney General, Parker was asked for assurance that the same legislation did not restrict human rights.

4. **Uncomfortable truths about a novel medical intervention have been sidelined.** The mRNA genetic vaccines were neither safe nor effective (they were never approved based on prevention of hospitalisation or death) from an early stage. Many of the international institutions the New Zealand government has depended on, have commercial conflicts of interest.[459]

5. **There has always been a less coercive strategy that would protect vulnerable groups.** Early treatments[460] prevent hospitalisation and death[461] yet this knowledge has been suppressed. Focussed protection[462] recommended protection of high risk and vulnerable groups to prevent the public health harms of lockdowns where negative consequences may outweigh benefits.[463] There were alternatives

[456] https://www.worldgovernmentsummit.org/community/partners
[457] World Government Summit (2022). World Government Summit Livestream: Day 1 https://www.youtube.com/watch?v=JTTDzH2A1tM
[458] World Economic Forum 2019. A Platform for Impact. https://www3.weforum.org/docs/WEF_Institutional_Brochure_2019.pdf
[459] Kennedy, R.F. (2021) *The Real Anthony Fauci*
[460] McCullough, P.A. et al. (2020). Multifaceted highly targeted sequential multidrug treatment of early ambulatory high-risk SARS-CoV-2 infection (COVID-19). *Reviews in Cardiovascular Medicine*, 21(4), 517-530. https://doi.org/10.31083/j.rcm.2020.04.264
[461] See for example: Sen. Ron Johnson COVID-19: A Second Opinion Panel Garners Over 800,000 Views in 24 Hours. (Invitation extended to relevant institutions). January 25, 2022 https://www.ronjohnson.senate.gov/2022/1/video-release-sen-ron-johnson-covid-19-a-second-opinion-panel-garners-over-800-000-views-in-24-hours
[462] Halperin, D.T. et al. (2021). Revisiting COVID-19 policies: 10 evidence-based recommendations for where to go from here. *BMC Public Health*, 21:2084. https://doi.org/10.1186/s12889-021-12082-z
[463] Bardosh, K. et al. (2022). The Unintended Consequences of COVID-19 Vaccine Policy: Why Mandates, Passports, and Segregated Lockdowns May Cause more Harm than Good. https://dx.doi.org/10.2139/ssrn.4022798

to a vaccine-only strategy, while promoting autonomy, protecting human rights and enabling medical choice which could prevent stress on the hospital system.

6. **Unprecedented state funding dismantled a critical media.** State reporting has mirrored government press releases and predominantly focussed on case counts and vaccine take-up. There has been an absence of critical reporting relating to mandates and vaccine efficacy and safety.

7. **Public institutions have been engaged to critique and discredit dissenting groups.** From February 2020 it was evident that the government foreshadowed contestation, due to persistent antinomies between case-oriented state messaging, contradictory information on risk embedded in the scientific literature. The Disinformation Project, appeared to be installed within Te Pūnaha Matatini for this purpose.[464]

8. **Medicalised cultures leave little room to counter the case/infection rate, vaccinate, mask and isolate narrative.** Legacy funding cultures direct researchers to medical expertise. This has left little space for autonomous collegial interaction across scientific and clinical communities that could be critical of pro-genetic vaccine narratives. Scientific, public health, ethical and legal experts that could talk to transdisciplinary complex socio-legal and socio-technical aspects have been silent. Not only are fundamental *democratic* norms collateral, but a utilitarian, medicalised approach has rendered fundamental *public health* norms impotent.

9. **The state's tactical approach has been accompanied by an unprecedented expansion of state power.** Despite the knowledge of the infection fatality rate in July 2021, in the second half of 2021 government Ministers released a barrage of policies and laws at an unprecedented pace, deploying narrow-in-scope modelling while eliding public discussion of infection fatality rate and risk by age and health status. [465] Policy and legislation was constructed to funnel the public to global acceptance of a medical intervention, a novel genetic vaccine rather than prioritising health.[466]

10. **The executive, legislative and judiciary has worked in concert to aggregate state power.** The executive, legislative (Parliament) and the judiciary co-operated to facilitate and promote vaccination, masking and mandates. These activities suggest that New Zealand lacks effective checks and balances to restrain the arbitrary use of state power.[467] Uncertainty in judicial decisions have weighed support in favour of mandates. Without a language that gives political and public actors permission to make values-based decisions and to be uncertain, science can be deployed to enhance state power.[468]

11. **The public must accept a medical intervention in order to engage in social and economic life.** Privacy has eroded, as vaccine passports and track and trace have been normalised throughout the population. Acceptance of a medical intervention in order to secure a freedom pass to economic and social life represents an erosion of fundamental democratic and human rights norms.

12. **Lacking appropriate public interest stewardship, future pandemics and the development of digital identity systems risk erosion of democracy.** The state's intention to fold the vaccine passports into the Digital Identity Services Trust Framework Bill is apparent. Digital identity involves important values-based questions of rights and privacy; and concern the related dilemma of increasingly unfettered institutional power (public and private, local and global). Such issues have

[464] Hannah, K. et al. (2021, Nov 9).Working Paper: *Mis- and disinformation in Aotearoa New Zealand from 17 August to 5 November 2021*. The Disinformation Project. Te Pūnaha Matatini. https://cpb-ap-se2.wpmucdn.com/blogs.auckland.ac.nz/dist/d/75/files/2017/01/working-paper-disinformation.pdf
[465] Pre-Omicron eg. Axfors C. and Ioannidis P.A. Infection fatality rate of COVID-19 in community-dwelling populations
[466] Nakagami, H. (2021). Development of COVID-19 vaccines utilizing gene therapy technology. *International Immunology*, 33:10;521-527. https://doi.org/10.1093/intimm/dxab013
[467] Palmer, G. & Butler A. (2018). *Towards Democratic Renewal*. Victoria University Press.
[468] Prasad, V. (2022). How the CDC abandoned science. February 15, 2022. *Tablet Mag.*

remained outside consideration in public-facing government communications.[469] The WHO clearly intends for vaccine passes to be used in future pandemics,[470] yet close relationships with vaccine producers generate opportunities for exploitation.

Note 1. UNPRECEDENTED LAWMAKING, UNPRECEDENTED PUBLIC CONSULTATION

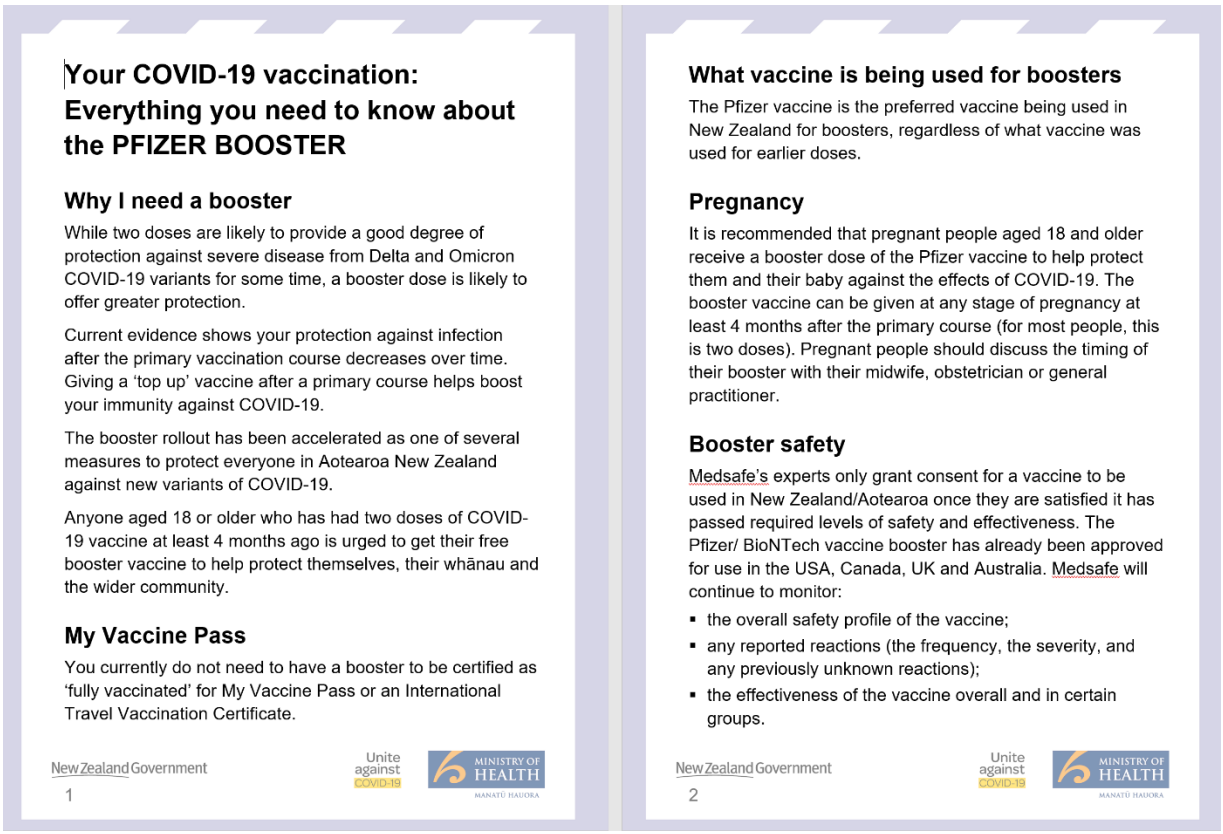
- **COVID-19 Response (Management Measures) Legislation Bill.** *6 days* Introduced May 5 2020 received Royal Assent 15 May 2020. Minister in Charge: Hipkins
- **The COVID-19 Public Health Response Bill.** *No public consultation 1 day*. Introduced May 12, Third reading and Royal Assent May 13 2020. Minister in Charge: Parker
- **COVID-19 Public Health Response Amendment Bill.** *No public consultation.* Introduced July 29, received Royal Assent August 6 2020. Minister in Charge: Woods
- **COVID-19 Response (Further Management Measures) Legislation Bill (No 2)** *No public consultation.* Introduced & passed August 4, 2020, Royal Assent August 6 2020. Minister in Charge: Hipkins
- **COVID-19 Response (Management Measures) Legislation Bill.** *No public consultation (some private consultation). 4 days.* Published October 1, closing date for submissions October 5 2020.
- **Inquiry into the operation of the COVID-19 Public Health Response Act 2020.** *One month.* Published May 21, closing date for submissions June 28 2020.
- **COVID-19 Recovery (Fast-track Consenting) Bill.** *5 days.* Published 16 June, closing date for submissions 21 June 2020, Royal Assent 8 July 2020. Minister in Charge: Parker
- **COVID-19 Public Health Response Amendment Bill.** *No public consultation.* Published and passed 1 December, Royal Assent 7 December 2020. Minister in Charge: Hipkins.
- **COVID-19 Public Health Response (Validation of Managed Isolation and Quarantine Charges) Amendment Bill.** No public consultation. Introduced 20 May, Royal Assent 24 May 2021. Minister in Charge: Hipkins.
- **COVID-19 Public Health Response Amendment Bill (No 2).** *11 days.* Published 30 Sept closing date for submissions Oct 11 2021.[xviii] Minister in Charge: Hipkins
- COVID-19 Response (Vaccinations) Legislation Bill. *No public consultation.* Bill introduced November 23, Royal Assent November 25 2021. Minister in Charge: Hipkins.

[469] PSGR (2021). Digital Identity Services Trust Framework Bill. Submission to the Economic Development, Science and Innovation Committee. December 16, 2021. Physicians and Scientists for Global Responsibility New Zealand. https://www.parliament.nz/en/pb/sc/submissions-and-advice/document/53SCED_EVI_116015_ED5348/physicians-and-scientists-for-global-responsibility-new

[470] WHO (2022, March 31) Digital Documentation of COVID-19 Certificates: Test Result. https://www.who.int/publications/i/item/WHO-2019-nCoV-Digital_certificates_diagnostic_test_results-2022.1

Note 2. Your COVID-19 vaccination: Everything you need to know about the PFIZER BOOSTER

February 2022.



Your COVID-19 vaccination: Everything you need to know about the PFIZER BOOSTER

Why I need a booster

While two doses are likely to provide a good degree of protection against severe disease from Delta and Omicron COVID-19 variants for some time, a booster dose is likely to offer greater protection.

Current evidence shows your protection against infection after the primary vaccination course decreases over time. Giving a 'top up' vaccine after a primary course helps boost your immunity against COVID-19.

The booster rollout has been accelerated as one of several measures to protect everyone in Aotearoa New Zealand against new variants of COVID-19.

Anyone aged 18 or older who has had two doses of COVID-19 vaccine at least 4 months ago is urged to get their free booster vaccine to help protect themselves, their whānau and the wider community.

My Vaccine Pass

You currently do not need to have a booster to be certified as 'fully vaccinated' for My Vaccine Pass or an International Travel Vaccination Certificate.

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1

What vaccine is being used for boosters

The Pfizer vaccine is the preferred vaccine being used in New Zealand for boosters, regardless of what vaccine was used for earlier doses.

Pregnancy

It is recommended that pregnant people aged 18 and older receive a booster dose of the Pfizer vaccine to help protect them and their baby against the effects of COVID-19. The booster vaccine can be given at any stage of pregnancy at least 4 months after the primary course (for most people, this is two doses). Pregnant people should discuss the timing of their booster with their midwife, obstetrician or general practitioner.

Booster safety

Medsafe's experts only grant consent for a vaccine to be used in New Zealand/Aotearoa once they are satisfied it has passed required levels of safety and effectiveness. The Pfizer/ BioNTech vaccine booster has already been approved for use in the USA, Canada, UK and Australia. Medsafe will continue to monitor:

- the overall safety profile of the vaccine;
- any reported reactions (the frequency, the severity, and any previously unknown reactions);
- the effectiveness of the vaccine overall and in certain groups.

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2

Potential side effects of Pfizer booster vaccine

How I might feel

You may experience some side effects, similar to those you might've had after the first or second dose, such as muscle aches, pain at the injection site or headaches. For most people these are mild effects. They are a sign your body's immune system is learning to fight the virus. They don't last long and for many people do not impact on day-to-day activities.

Rare side effects

Allergic reactions

There are some side effects that are more serious but rare, like a severe allergic reaction or anaphylaxis. This is the reason people are observed for around 15 minutes post vaccination. Vaccinators are welltrained in managing these reactions if they occur.

Myocarditis and Pericarditis

Myocarditis is inflammation of the heart muscle, while pericarditis is inflammation of the tissue forming a sac around the heart. These conditions are usually caused by viral infections (including COVID-19), but they are also very rare and serious side effects of the Pfizer vaccine.

Symptoms of myocarditis or pericarditis linked to the vaccine generally appear within a few days, and mostly within the first few weeks after having the vaccine. If you get any of these new symptoms after your vaccination, you should seek medical help, especially if these symptoms don't go away:

- tightness, heaviness, discomfort or pain in your chest or neck;
- difficulty breathing or catching your breath;
- feeling faint or dizzy or light-headed;
- fluttering, racing or pounding heart, or feeling like it is 'skipping beats'.

If you feel any of these symptoms in the days or weeks after the vaccine, you should seek medical help. There will be no charge for the consultation.

You can also call Healthline on 0800 358 5453 anytime to get advice. If you have an immediate concern about your safety, call 111, and make sure you tell them you've had a COVID-19 vaccination, or have or had COVID-19 so they can assess you properly.

You can report any side effects you experience at: report.vaccine.covid19.govt.nz.

Getting a booster

If you are 18 years and older you will be able to get a booster dose the same way you got vaccinated with your primary course. For most people, a primary course is two doses. For people who are severely immunocompromised, a primary course could be three doses.

When you arrive for your booster, the date of your last dose will be checked in the booking system to ensure it has been at least 4 months since you completed the primary course.

You can check when you are due for a booster by visiting mycovidrecord.nz or if you have one, referring to your purple COVID-19 Vaccine Record Card.

To book an appointment for your booster go to: BookMyVaccine.nz.

You can also get a booster at a walk-in clinic, pharmacy or your GP. If you're unable to book online, you can call the COVID-19 Vaccination Healthline on 0800 28 29 26 (8am to 8pm, 7 days a week). We'll make the booking for you and answer any questions. Interpretation services, and text, email and NZ Relay options for deaf and hearing impaired are available if you need them.

- Free text: 8988
- Email: accessiblecovidvaccinations@whakarongorau.nz

The disability team is available Monday to Friday from 8am to 8pm. Call 0800 28 29 26 and select option 2.

End of information for: Your COVID-19 vaccination: Everything you need to know about the PFIZER BOOSTER